State Registrar

OCME 2006

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signa

Carol Allan, MD

31. Date filed (Month, Day, Ye

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Amend Item 28f per me, g876 02/120/108/hbeath

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** George George 2058 13 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death . Examiner Keninsula Regional Salisby M CENTER HICHMION If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1**X** M 2□ F 8/1/1928 Director 79 West Virginia 233-42-1028 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notifled at 1 X Yes 2 □ No Directo Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 510 Elberta Ave. 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Givenir Force 1 Never Married 2 Married 1 ☐ Yes 2 X No þ Specify: 3 Widowed 4 Divorced white Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natun any injury or other traumatic event, the Medical ang." 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) salesman shoe 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George D. George Adele Thabet ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 510 Elberta Ave., Salisbury, MD 21801 Elizabeth George/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 □ Removal from State Parsons Cemetery 1/28/08 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD 21 Sunature of Funeral Service Cense 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between diate Cause (Final FIACULE Physician days /Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by obstructive pulmonary No 3 Probably 4 Unknown 1 Tyes congestive heart failure 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 sl Division or Vital 2 No 1 Yes Hospital or Attending Physician: 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 🗷 No within 24 hours after death.

To the Funeral Director: Accompletely filled in by the fi 1-15-2008 6:00 PM fell from CHAIR 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Home 510 Elberta Ave., Salisbury, MD 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Etaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certified 29c, License number 29d. Date signed (Month, Day, Year) MY 1VX 30. Name and address son who completed cause of death (Item 23a) (Type, Print) PRIGNOLI 100 E. CARUN ST. C.B. SILVIA

State

Registrar

31. Date filed (Month

gistrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #2, perMD, g876, 2/21/08 TT Certificate of Death 2. Date of Death Jan. 29, 2008 1. Decedent's Name (First, Middle, Last) Physician Month Harold 30,2000 10:30 p<sup>M</sup> Hartman Vincent <del>Janua</del>1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Manor Care-Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 1 M 2 □ F Director 579-34-1950 85 Jan. 24, 1923 Washington, DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene. 10c. City, Town or Location 10b. County 10d. Inside City Limits show if than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3158 Gracefield Road, FC105 20904 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2€ Married 1 ☐ Yes 2 📈 🖈 o Specify Completed by 3 Widowed 4 Divorced Year or Dates: White WWII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Wholesale Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner/Operator Distributions 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be if Health and Menta James Olin Hartman Helen Madeline Blandford other traumatic 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 Ellen C. Hartman/ Wife 3158 Gracefield Road, FC105, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot N Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 11, 4 □ Donation 5 □ Other (Specify) Heaven Cemetery 2008 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. Schard I Hales 500 University Blvd. W., Silver Spring, MD 20901 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration Pneumonia 2 Weeks /Medical Due to (or as a consequence of): Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Years Due to (or as a consequence of): Examine and burial-trai Due to (or as a consequence of) physician Physician/Medical the IF FEMALE for use If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown à cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 2**X** No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

Examiner death certificate be executed Ö مَ

Maryland 21215-0036

Baltimore,

certificate this funeral After ours after death.
neral Director: A within 24 hours To the Funeral

Certification: To

Medical

State

Registrar

completely

27. Manner of Death

1X Natural

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

Division or Vital Records,

Attending

ö

1 | Inpatient

2 ER/Outpatient 3 DOA 28b. Time of (Month, Day Year)

28c. Injury at Work? Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D17874

29d. Date signed (Month, Day, Year) January 30,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. M. Nayar, MD 3717 38th Avenue, Cottage City, MD 20722

28a. Date of Injury

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

FEB 01 2008

5 Pending

investigation

determined

6 ☐ Could not be



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Dhi-i		Registrar  1. Decedent's Name (First, Middle,Last)		Cer	uncate of	Deali			Reg	J. 140.	3. Time of Death
Physicia edical Exami		Carv Lee Hatfield								Day Year	2323 hrs
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		2025 Suffolk Road				Finksl	burg			Carroll	
Funeral		5. Social Security Number 6. Sex	7. Age	e (In yrs. Ia	ist birthday)	If Unde	r 1 Year s Days	If Under 24Hi	n.	Forei	
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á		Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Locat	ion					10d. Inside City Limits
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arylan 8a-fsl	Director	10e. Street and Number		I'IC	a icijest	10f. Zip	Code		10	g. Citizen of What Co	intry?
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5-00 ed wii tygier other	Co	17. Father's Name (First, Middle, Last)					1	8.Mother's Nan	ne (First, Middle, M	laiden Surname)	
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Baltimore, MD 21215-0036  gernit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important of Fleding and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	70	19a. Informant's Name/Relationship (Type, F Brenda Hatfield/wife	,							ber, City or Town, Star MD 211	
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		or condition resulting in death) Due to	(or as a conse	equence of	F):						
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ords, P.O. Box 68760, w requires that the death certificate be seen signed by the attending physici should be detached for use as the buri	Physician/Medi		c. If yes, outcor	ne of preg	nancy		-			23d. Date of delive	
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Division of Vital Records, so and retuing Physician: The law requires and eard earl. After this certificate has been seled in by the funeral director, page 2 should the control of the co	on:	27. Manner of Death  1 Natural 5 Pending	8a. Date of Inju FOUND:	rear)	FOUND:	injury	•	res 2 No		ten and stabbed	
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Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physician: 1	o the best of m	y knowled	ge, death occu	rred at the	e time, da	ate and place, a	and due to the caus	e(s) and manner as st	ated.
Fo the vithin Fo the	Medical	one) Medical Examiner:On t	ne basis of exa manner stated.	mination a	nd/or investiga				d at the time, date		
	Ž	29b Signature and title of certifier		)		29		e number		29d. Date signed (A	
		Malorle	ul)	/	JEC		O.C.	IVI.□.		January 27, 20	
WJL- 15+	10	30. Name and address of person who compl Laron Locke MD. Assistant	eted cause of d Medical Ex			n Street	t. Baltir	nore, MD 2	1201		
	tate	31. Date filed (Month, Day, Year)	32. Registra			-	.,				
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3	Funeral		Social Security Number	6. Sex 7. Ag	ge (In yrs. last birthday)	If Under 1 Year	If Under 24 H	Irs. 8. Date of Bir	th		place (State or atry)	Foreign
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	D		Usual Residence of Decedent									
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	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizer	of What Cour	ntry?	
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	dea ems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi	ispanic Origin?	(Specify Yes or No	)- 14.	Race - Americ Black, White,		
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Madical Examiner must be notified at ance.		21. Signature of Funeral Service I	Licensee		2. Name and Addres	- 0	Stauffer :				771
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Box 687	leath certificate be attending physici	dical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d	pf pregnancy 2 □ Fetal death 3 □	⊒Ectopic pregnancy			23d	. Date of delive	ery Day Ye	ear
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DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760, within 24 hours a To the Funeral I

29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

nt (trad 23a) (Type, Print) 2401 Brandermill Blvd., Gambrills, MD 21054 30. Name and address of person who completed cause of the FREA DAVID GWIN

31. Date filed (Month, Day, Year) State

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32. Registrary Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H. Breeks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year January 30, 2008 **Physician** 7:46a Ruth Edith Kent /Medical 4a. Facility Name (If not institution, give street and number) 5 400 more 4b. City, Town, or Location of Death 4c. County of Deatl **Examiner** Rd-Acres 69 erwoo OMPY 6000 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 057-18-1208 1 □ M 2 □ F 86 Yrs. Aug. 3, Director 1921 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nnent of Health and Mental Hyglene. and the than "natural", or Items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ant: If Item 27 is marked other than "natural" or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d, Inside City Limits 10a. State 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 20906 USA 2901 Beaverwood Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☑ No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Conference Coordinator Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard E. Owen Mae A. McCall 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3111 Dawson Avenue, Wheaton, MD 20902 Craig S. Kent/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Feb. 6, Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any Injury or Arlington Nat'l Cemetery 2008 Arlington, Virginia 21. Signature of Funeral Service Vicensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, Kukard L Dales MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician s the burial Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has l e 2 s autopsy certificate To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ٩ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. within 24 hours after death **To the Funeral Director**: сотрletely filled in by the f 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Situ ature and title of certifier netical Park Dr. MDOME

State Registrar

31. Date filed (Month, Day, Year)

FEB 01

DHMH 17 Rev 1/2001

MO OME

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRECKER

2008

State of Maryland / Department of Health and Mental Hygiene 2008 04509 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 7:40 AM February 5, 2008 Marcia Elizabeth Kemp /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Joppa 702 Joppa Farm Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1□M 20F Mar. 4, 73 1934 New York Director 043-28-3734 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County r than "natural", or items 23s or 28s-f ehow the Medical Examinar must be notified at 1 Tyes 2 XNo Director Maryland Harford Joppa 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code 21085 USA 702 Joppa Farm Road Completed by Funeral 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) within 7 al Hygiene. College (1-4or 5+) Flementary/Secondary (0-12) Auditor Health Insurance 4 s 1 and 2 should be filed to if Health and Mental Hygie item 27 is marked other to other traumatic event, it 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be Elizabeth Wilhelmina Warfel Arthur William Kemp ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) or other train Robert J. Kemp / Brother 3 Hillside Avenue, Vernon, CT 06066 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Pages 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Depertment of Important: If eny injury or once. 2-8-08 Hilltop Service Corp Towson, Maryland 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, Maryland 21009
Approximate 21 Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the drath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear filture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 25415 **Physician** YPEIL DIABETES resulting in death) /Medical Du.,t. (or as a consequence of): Examiner PERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physicien and s the burial-transit PERCHOLESTEROLEMIA that initiated events resulting in death) Last Division to (or as a consequence of) Physician/Medical as guip IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atten for u in the past 12 months? Year Month Day 4□Pregnant at time of death 5 Other (specify) P.O. I signed by the a 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown POTHYRO IDISM peeu 24b. Were autopsy findings available prior to completion of cause of death?

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		1 = For State Registrar	State of Marylan		artment of I		Mental Hy	/giene	2008	045	10
Physic		1. Decedent's Name (First, Middle, Last) Paul C. Leckey					Jan.		008 Year	3. Time of 2:12	Death Рм
/Med Exam		4a. Facility Name (If not institution, give st Civista Medical Cer		-	4b. City, Town, o	or Location of Death			County of Death Charles		
Funera Directo		/15-12-3/3/	7. Age (In yrs. 91	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of B (Month, D bruary	ay, Year)	9. Birth Cou	place (State or intry) PA	Foreign
Maryland a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  MD Charle		y, Town or Lo	cation		-			10d. Inside Cit 1 ☐ Yes	•
with the	I Dire	10e. Street and Number 13070 Hickory Ave			10f. Zip Code 2060	11		10g. Citiz	zen of What Cou USA	intry?	
d within 72 hours after death with the Maryland giene.  sr then "natural", or iteme 23s or 28s-f show it a Macdical Exertiner must be neitlied at	by Funeral Director		2. Was Decedent Ever in U Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates:			Hispanic Origin? (Sp pan, Mexican, Puerto	pecify Yes or No Rican, etc.)		14. Race - Amer Black, White Specify: Wh	, etc.	
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		19a. Informant's Name/Relationship (Typ Donna Pickera1/Da				t and Number or Ru 7 Ave., Wa		-	r Town, State, Zi 0601	ip Code)	
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permit. Pages Department of I Important: If its any injury or o		21. Signature of Funeral Service License	M00945			CHOLS FUN	ERAL HO				
Physiciar /Medica Examine	1	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.			ing, such as cardiac		arrest,		Approximate Interval Bett Onset and E	ween
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T with	~	29b. Signature and title of certifier	Jaum	/ W.C	). D	00 404	19		te signed (Month		
iB154	1	30. Name and address of person who con	Davison J.	IM a		old Line (	Center,	Suite	100,Wa	ldorf,M	D206
S Regis	tate trar	31. Date filed (Month, Day, Year) FEB 0 1 2	32. Reffistrar's Sign	ature #	banks						

### State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Harvey Elton Larsen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** pastal Huspice at The alisbur If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1**X** M 2 ☐ F 529-03-5028 93 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at Directo Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 28273 Nanticoke Road 21801 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Spec If Yes, specity Cuban, Mexican, Puerto F 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Army 1 ☐ Never Married 2 ☑ Married Larse Harvey Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Army Corp of Engineers and Mental Hygir Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic ev Harvey Ezekiel Larsen Sylvia N 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural 28273 Nanticoke Rd., S Mary E. Larsen/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 2/4/0 Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Ho Javie H. 501 Snow Hill Rd., 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) **Physician** DEMEN TI /Medical Due to (or as a consequence of): Examiner PNRUMO PIRATIO Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed page 2 certificate 25. Was case referred to medical examiner? Be 26. Place of Death Hospital: Other: 4 Nursing Home 142 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Funeral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28 4 Homicide

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Registrar

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29a. Certifier

(Check only one)

6 Hungan

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

WARY

FEB 0 4 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 24 To the Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Walnergue Louisfun 062823289 Fur Dire permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural", or items 23a or 28a-f show Baltimore, Maryland 21215-0036Physic /Med Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division or Vital Records, P.O. Box 68760,

		Please Type or Print in Black Indelible Ink. En State of Maryland / Department of Healt		•	•	
		For State of Maryland / Department of Fleating		Reg. No	0000	01.513
		Negistrar  1. Decedent's Name (First, Middle, Last)		. Date of Death		3. Time of Death
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amin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Locati	tion of Death	40	. County of Death	
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uer m	nue	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Wever Married 2 □ Married  1 □ Yes 2 □ No	c Origin? (Speci xican, Puerto Ri	fy Yes or No- can, etc.)	<ol> <li>Race - America Black, White, e</li> </ol>	
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any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type. Print) Brothe 19b. Mailing Address (Street and Nu	umber or Rural I	Route Number, City	or Town, State, Zip	Code)
her tra			treet S	alisbury	MD 21	V - I
or ot	- 1	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	Dat		ocation - City or To	vn, State
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completely filled in by the funeral director, page	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, dat 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.	te and place, an	d due to the cause( t at the time, date ar	s) and manner as st nd place, and due to	ated. the cause(s)
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)		Dool	4152	10	m 24,	2008
Y		29b. Signature and title of certifier  29c. License numb  DOG  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  MICHAEL BASILEL M.D. 100E, CARROL ST.  31. Date filed (Month, Day, Year)  FEB 0 1 2008	-		A 4	
Sta	te	MICHAEL BASLIEC, M.D. 100E, CARROL ST. 31. Date filed (Month, Day, Year) 32. Registra's Signature	JAU	SBURY,	MD 218	01
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State Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State AMEND#18perFH2/11/08,BMW,McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2:05 a M January 30, 2008 Helen J. Myers 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Mount Airy Carroll 3803 Boteler Road If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min. 1 □ M 2 🖾 F 5, 215-54-9838 1921 Nebraska March Usual Besidence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Maryland Mounty Airy Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21771 3803 Boteler Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 21⁄2 No Specify: 3 ₩ Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) Loretto Donovan 17. Father's Name (First, Middle, Last) James W. Trumble Robert Myore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colleen M. Histon/Daughter 3803 Boteler Road, Mount Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Feb. 2, Gate of Heaven Cemetery 4 Donation 5 Other (Specify) 2008 Silver Spring, Maryland 21. Si Ture Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. Kekard Z J feles 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition disease or condition resulting in death) 4 weeks a Rectal Bleeding Due to (or as a consequence of): b. Multiple Myeloma

Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 1 year Due to (or as a consequence of)

**Physician** /Medical Examiner

Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumation

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

r 28a-f show notified at

"natural", or items 23a or dical Examiner must be r

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Director

Funeral

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Completed

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within 72 hours after

Baltimore, Maryland 21215-0036

be executed attending physician the 98 nse ŏ the signed by

Box 68760, ←

Records, P.O.

Division or Vital

Examiner Physician/Medical by Completed page 2 certificate Be P this After t Certification: To the Hospital or Attendi within 24 hours after death. To the Funeral Director: ₽ filled in by the

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No

25. Was case referred to medical examiner? 1 🗌 Yes

27. Manner of Death

29a. Certifier

Medical

2€ No

1x Natural 5 Pending investigation 2 Accident 3 ☐ Suicide

6 ☐ Could not be determined 4 ☐ Homicide

1 Inpatient 28a. Date of Injury (Month, Day Year)

28b. Time of

2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D18813

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

January 31, 2008

30. Name and address of person who completed cause of death (Item 23a) (Tyes, Frint)

Hospital:

Ira Tauber, MD 10301 Georgia Avenue, #304, Silver Spring, MD 20902

31. Date filed (Month, Day, Year) State

> FEB 01 2008



DHMH 17 Rev 1/2001

Registrar

DHMH 17 Rev 1/2001

State Registrar

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**OFIGINAL** 

Glosur S. Spark

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04515 State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 30, 2008 9:45 AM Mary Frances Murray /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Homewood at Crumland Farms Frederick 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Months Days Hours Min. | May 18, 1914 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕏 F Indiana 317-18-6889 Director Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State other then "naturel", or Items 23a or 28s-f ehovent, ite Medical Exacting must be notified at 1 ☐ Yes 21 No Maryland Frederick Frederick Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code United States 7407 Willow Road 21702 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White Completed by 3 Midowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Manager Bar/Restaurant permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent; if fem 27 ie marked othnamy Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gertrude Winters David Shinn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) William Gentel / Son 5159 Ijamsville Rd., Ijamsville, MD 21754 20b. Place of Disposition (Name of comptent cranatory of other place) 20a. Method of Disposition Feb. 2, 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Frederick, Maryland Memorial Gardens 21. Signature of Funeral Service Licensee Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 FIGURE STATE FINE THE PROPERTY OF THE PROPERTY Approximate Interval Between Onsel and Death Immediate Juse (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) ate has been signed by the attending physician page 2 should be detached for use as the burial P.O. Box 68760, by Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No neral Director: After this certific filled in by the funeral director. To Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 💆 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 5 To the Hospitel o within 24 hours aft To the Funeral Dia 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner/state(d. Medical 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Pay, Year) 30. Name and address of person who completed cause of death (It in 23a) (Type, Print) 300 West 9th Street, Frederick, MD 21701 Casper Cline, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FEB 0 1 2008

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physicians as: many munner

State of Maryland / Department of Health and Mental Hygien [ ]

2. Date of Death Month

JANUARY 31

911/LUSSOII Avenue GaitHersburg, MD20279

Day

2008

Certificate of Death

Priscilla cullation-tyon mo

31. Date liled (Month, Day,

Decedent's Name (First, Middle, Last)

**EDWARD** 

MORGAN

CHARLES

**Physician** 

Examir

**Funeral** Director

3. Time of Death

3:45 P

04516

		not institution,	give street and	number)		41	b. City, Town, o	r Location of D	eath	4c.	. County of	D	
ai er	4a. Facility Name (If											Death	
	WILSON H	EALTH (	CARE				GAIT:	HERSBUR	G		MONTO	SOMERY	
	5. Social Security Nu 705-14-0		6. Sex 1 M M 2 ☐ F		(In yrs. last I		f Under 1 Year fonths Days	Hours N	lin. 8. Date of B (Month, D Oct.	ay, Year)		Birthplace Country) Maryl	(State or Foreig
	Usual Residence of												
	10a. State	10b. County		1	*	own or Locati							nside City Limit
runeral Director	Md.	Mont	tgomery		G	Saither	rsburg					1	Yes 2□N
0	10e. Street and Num	iber					10f. Zip Code			10g. Cit	tizen ol Wh	at Country?	
2	333 Russ	ell Av	enue				20	877		Ur	nited	State	S
5	11. Marital Status		12. Was [	ecedent Ev	rer in U.S.	13. Was	s Decedent of H	lispanic Origin	(Specify Yes or Nento Rican, etc.)		14. Race -	American In	
2	1 Never Marrie	• -	d 1 <b>X</b> 1Ye	Forces?  S 2 No Give or Dates:	WWII		es, specify Cuba	Specify:	ierto Hican, etc.)		Black, Specify:	White, etc. Wh	ite
nonibleten	(Speci		grade complete			(Give kind	t's Usual Occup d of work done NOT use retired	during most of	working	16b. K	ind of Busin	ness/industr	у
1	Elementary/Secon		2	e (1-4or 5+)	)		nister	<i>-</i> )			Cler	gy	
3	17. Father's Name (I			_					Name (First, Middle		Sumame)		
0	Charles	Edward	a Morga	an, Sr	r.			Alic	e Birkı	neir			
	19a. Informant's Na					9b. Mailing A	Address (Street	and Number of	Rural Route Numi	ber, City o	or Town, Sta	ate, Zip Cod	(e)
	Charles	Norris	Morgan	/ Sor	n	8713 V	Warm Wa	ves Way	, Columb	ia, N	4d. 2	21045	
1	20a. Method of Dispo	Cremation 3		om State	ceme		ory or other plac		Date			ty or Town,	
	4 Donation	11			Metr	ороти	tan Cre	m. / 2	/2/08	Al	Lexano	dria,	va.
	21. Signature of Fur		-	0.			ame and Addre		er Funera	al Ho	me.		
	mur	Lev J	(     1   2					II DULL				-1 00	000
						E	P. O. :	Box 503	8, Layton	nsvil	lle, N	<u>1a. 20</u>	882
	23a. Part1. Enter th	e disease, or c		at caused th	ne death. De	E	P. O. :	Box 503 ig, such as care	8, Layton	nsvil arrest,	lle, M	App	proximate
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State Registrar

		-	For State Registrar	State of I	Maryland / Dep <i>Ce</i>	artment of F			giene Reg. No. 2008	04517
	Physici		1. Decedent's Name (First, Middle					2. Date of Dea Month	ath Day Year	
	/Medic	al	ROWENA STETSON		1	Ab City Town	- Leasting of		3/2008 4c. County of De	12:47P M
	Examin	er	4a. Facility Name (If not institution	give street and numb	er)	4b. City, Town, o				atn
	Funoral		HERON POINT  5. Social Security Number	6. Sex 7.	Age (In yrs. last birthday	If Under 1 Year		4 Hrs. 8. Date of Birtl	h 9. B	irthplace (State or Foreign
	Funeral Director		559-26-8933 Usual Residence of Decedent	1□M 2 <b>X</b> 2F	87 Yrs.	Months Days	Hours	Min. (Month, Day 6/30/19	920	CA CA
	yland 10w		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	e-f sl	Director	MD	KENT	CHESTER	RTOWN				1 XYes 2 No
	or 28	Olre	10e. Street and Number			10f. Zip Code			10g. Citizen of What (	Country?
	ath w	ra l	501 E CAMPUS D			21620			USA	nerican Indian,
920	d within 72 hours after death with the Maryland Jiene. I then "neturel", or tlems 23e or 28e-f show The Marical Examinational be motified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marri  3 ◯ Widowed 4 □ Divorced	12. Was Decede Armed Force ed 1 Tes 2 If Yes, Give Year or Date	No No	Was Decedent of I If Yes, specify Cub		n? (Specify Yes <i>o</i> r No- Puerto Rican, etc.)	Black, Wh	
21215-0036	nin 72 ho .i m "netur Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education t grade completed)  College (1-4	(Giv	edent's Usual Occup e kind of work done DO NOT use retire	during most d	of working	16b. Kind of Busines	ss/Industry
21	d within glene.	E O	12	4		NISTRATIV	E SECR	ETARY	HEALTHCA	RE
Maryland	be filed htal Hygi ed other event, I	Be	17. Father's Name (First, Middle,					s Name (First, Middle,		
yla	should be nd Mental marked o	္	PHILIP C. STET		1.00			OTHY PILSBU		7-0-4-1
Mar	12 sho h and l 7 Is me treume		19a. Informant's Name/Relations					or Rural Route Numbe		
	s 1 and 2 should if Health and Mer item 27 Is marke other treumetic	1	CARLA WITTEN/D.  20a. Method of Disposition	AUGHTER	20b. Place of Disp	osition (Name of	1	D. CHARLOT'	20c. Location - City	
nor			1 Burial 2 Cremation 4 Donation 5 Other (S)		919	matory or other pla	1	2/4/2008	STEVENSVI	TIR MD
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service		F	22. Name and Addre	ess of Facility	BEIN & NEWN	NAM FUNERA	L HOME, PA
÷			23a. Part1. Enter the disease, or	complications that cau	sed the death. Do not er			<b>HESTERTOWN</b> ardiac or respiratory ar		Approximate Interval Between
	Priysician		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)		PHYSEW	A				Onset and Death
П	/Medical Examiner		rosalling in obally	Due to (or	as a consequence of):					
	ed isit	ulner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consequence of):					
8760,	be executed sician and burial-transit	I Examine	that initiated events resulting in death) Last	cDue to (or	as a consequence of):					
	physic	dlcal		d						
.O. Box 6	at the death certificate be executed by the attending physician and tached for use as the burral-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		h 2 ☐ Fetal déath 3 ht at time of death 5	□Ectopic pregnand □ Other (specify)	;y		23d. Date of o Month	delive <b>ry</b> Day Year
<u>α</u>	as the	by	Part II. Other significant condition	ns contributing to dea	th but not resulting in the	underlying cause gi	ven in Part I.	23e. Did to		e to the cause of death?  Probably 4 □Unknown
Vital Records,	0 L 0	Completed							an 24b. Were prior to death 2 No 1 1 Y	
ital	sicien: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?				26. Place	of Death (Check only of		
of V	dis dis	20	1 ☐ Yes 2 No	Hospital: 1 ☐ Inp		ent 3 DOA		sing Home 5 ☐ Resid		pecify)
n o	ding Ph h. After th funeral	on:	27. Manner of Death  1 Matural 5 ☐ Pendin	28a. Date of (Month,	Injury 28b. Time Day Year) Injury	Wo			how injury occurred	
Sio	Attending r death. ector: After by the fune	cat	2 Accident investig	not be	Flairer Athama form		]Yes 2. □N		Street and Number or	Rural Route Number
Division	iel or Attenis after deat	Certification;	4 ☐ Homicide determ	ined 288. Place o building	f Injury - At home, farm, s , etc. <i>(Specify)</i>	treet, factory, office		City or Tov		Travar Trouts Training,
	To the Hospitel or a within 24 hours after To the Funerel Direct completely filled in b	edical (			est of my knowledge, dea is of examination and/or r stated.					
)	To the within 2 To the complet	M	29b. Signature and title of certifie	None	_ MD		DO04	1587	29d. Date signed (Md	onth, Day, Year)
			30. Name and address of person		of death (Item 23a) (Type	o, Print) Cheste	rtown	1, WD 21	620	
	Sta Registi		31. Date filed (Month, Day, Year)	32. Rec	ar's Signature	feel	, -	1, ND 21		
						4				

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day 0/35 FLOYD MATTHEWS, III 2008 **JAMES** /Medical Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner SalisbuM NICOMICO ininsula Regional Medical If Under 1 Year TV Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Yes 4/21/1955 Social Security Number 7. Age (In yrs. 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 □ F Months Hours 52 Yrs. 216-70-2086 Virgińia Director Usual Residence of Decedent with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f sh notified 1 XYes 2 □ No Directo Worcester Pocomoke City 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or i USA death v 1006 Market Street 21851 Funeral 'natural', or items dical Examiner m 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 2 🗷 No altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene. 27 Is marked other than " r traumatic event, the Mec Elementary/Secondary (0-12) College (1-4or 5+) 12 Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mildred Marshall James Floyd Matthews, Jr. ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trauonce. 34027 Clearfield Dr., Pocomoke City, MD 21851 Carol M. Taylor (sister) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Assawaman Meth. Cemetery 1/31/2008 Assawoman, Virginia 21. Signature of Funeral Service Licensee Holloway Funeral Home, Professional Association 103 Linden Ave., Pocomoke City, MD 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner THEYMONIA Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-tra Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed icate has been s , page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day Year) Injury 5 Pending investigation To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 □ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier TICertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12008 HO059368

DHMH 17 Rev 1/2001

State Registrar NOUN

31. Date filed (Month, Day, Year)

V131021

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ORIGINAL

100 E CATION

SAUSBUM

address of person who completed cause of death (Item 23a) (Type, Print

32. Registrar's Signature

			1 - For State Registrar			ertificate of			g. No. 200	18 04519
П	Physici	an	Decedent's Name (First, Middle, Last	)				Date of Death     Month	Day Yea	3. Time of Death
	/Media		ELIZABETH	т.	MU	RRAY		JAN	31 200	
	Examir	er	4a. Fecility Name (If not institution, give			4b. City, Town, o		eath	4c. County of De	
-	Foresal		ATLANTIC GENERAL  5. Social Security Number 6. Se		n yrs. last birthday	BER		Hrs. 8 Date of Birth	WORCES	TER inhplace (State or Foreign
	Funeral Director			THE OFF	73 Yrs.	Months Days		Hrs. 8. Date of Birth (Month, Day, MAY 25,	1934 DE	Country) LAWARE
	ylanc		10a. State 10b. County	10	C. City, Town or L	ocation				10d. Inside City Limits
	a-f-	cto	DELAWARE SUSSEX		SELBYVI	LLE				1 ☐ Yes 2 X No
	or 28	Öİre	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
	ath w	ia	14 KEENWICK ROA			1997			USA	
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f ehow ha Medical Exeminar must be multised at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	rin U.S. 13	Was Decedent of H If Yes, specify Cub	Hispanic Origin? an, Mexican, Pu Specify:	? (Specify Yes or No- uerto Rican, etc.)	Black, Wi	nerican Indian, nite, etc. WHITE
Ą	72 ho	ted	15. Decedent's Edu	cation	16a. Dec	edent's Usual Occup	pation	1	6b. Kind of Busines	s/Industry
21	thin 7	pie	(Specify only highest grad	College (1-4or 5+)	life.	e kind of work done DO NOT use retire	during most of d)	working		
2	be filed within 72 hours ital Hygiene. d other then "natural, event, ine Medical Exp	Completed by		5	Т	EACHER	r		ELEMEN	TARY
Maryland	D 2 2 0	To Be	17. Father's Name (First, Middle, Last) HAROLD	TIMMONS			18. Mother's i	Name (First, Middle, M H	aiden Sumame) BRITTINGH	AM
	s 1 and 2 shoul I Health and Mi Item 27 le marl other traumati		19a. Informant's Name/Relationship (Ty KEVIN HOLM-HUDSON					GTON, KY 40		, Zip Code)
Baltimore,	00-		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ F 4 □ Dopatton 5 □ Other (Specify)	lemoval from State	-	osition (Name of or other plant of OF DELM	· 1		Oc. Location - City of DELMAR, D	
Salti	permit. Peg Depertment Important: I eny injury o		21. Signature / Funeral Service Lucens		2	2. Name and Addre	ss of Facility			
	00 E • 0		July	Hud/	1			HOME, SELB		
,	Pnysician /Medical		23a. Part . Enter the disease, or complishook, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	herotic	Coloral ibus		THAT O	st,	Approximate Interval Between Onset and Death
	Examiner		-	Due to (or as a co	onsequence of):					
(7)	cuted nd ransit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	onsequence of):					
3/60,	cate be executed hysicien and the burial-transit	icai	resulting in death) Last	Due to (or as a co	onsequence of):					
õ	ing pt e as t	Med	IF FEMALE:							
O. BOX	the death certificate y the attending phys ched for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ② No 9 □ Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)	<u>'</u>		23d. Date of d Month	elivery Day Year
cords, P	law requires that the de as been signed by the 2 should be detached	ğ	Part II. Other significant conditions cor	ntributing to death but no	ot resulting in the	underlying cause giv	en in Part I.			to the cause of death?  Probably 4 Unknown
Ž L	4 00 00	Completed						24a. Was an autopsy perform	prior to	autopsy findings available completion of cause of
	ician Sertifi Botor	Be	25. Was case referred to medical examiner?			7 -		Death Check only one		
о по	ng Phy fter this	Itlon: To	1 Yes 2 No  27. Magner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	2 ER/Outpatie 28b. Time ( lnjury	of 28c. Injur Wor	y at	g Home 5 Residen		ecify)
DIVIS	To the Hospital or Attending within 24 hours effer death. To the Funeral Director: After completely filled in by the funeral or the funeral o	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, st specify)	reet, factory, office		28f. Location (Stre City or Town,	et and Number or I State)	Rural Route Number,
	he Hospit in 24 hour he Funar pletely fills	Medical	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the best of moner: On the basis of exa and manner stated.	mination and/or i	th occurred at the tin	ne, date and pla pinion, death or	ace, and due to the cau ccurred at the time, dat	se(s) and manner a e and place, and di	as stated. ue to the cause(s)
	with Com	Σ	29b. Signature and title of certifier	ulr,		29c. Licens			d. Date signed (Mod	
	100	~	30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type	Print)	11.	Fo	151	1 00-
	Sta	e	31. Date filed (Month, Day, Year)	32. Registrar's	Signature .	wage	rege	ug 1 can	we yeve	al De 1994
	Registra		FFB 0 4 2	008	- 15 p	فستناعث		•		

Registra DHMH 17 Rev 1/2001

**OCME 2006** 

Mylyme

Margarita Korell MD.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

2008

Assistant Medical Examiner

32.

egistrar's Signature

MELLE -

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

February 3, 2008

			_ For	State o	f Marylan	d / Depa	artmen	t of H	lealth a	and M	lental Hyg		gibie.		- 0 1
			1 - State Registrar	- (4)		Ce	rtificati	e of i	Death		2. Date of Dear	eg. No.2	008	() 4 5	521
100	Physici		1. Decedent's Name (First, Middle Gretchen Annett		•						Month  JAN	Day 30	Year 2008	3. Time o	P M
	/Medic Examir		4a. Facility Name (If not institution				4b. City,	Town, or	r Location (	of Death	JAM		unty of Death	1	т
			Althea Woodland						Spring				lontgom		
	Funeral Director		5. Social Security Number 577-07-2843	6. Sex 1 □ M 2 <b>X</b> F	7. Age (In yrs. 90		If Under Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day) NOV 20,	<sup>Year)</sup> 1917	Cou	place (State ontry) ngton,	
	yland Iow at		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside C	ity Limits
	e Man Ba-f sh tified	Director	Maryland Montg	omery	Sil	ver Sp	ring							1 🗌 Yes	2 <b>∑</b> No
	with th	Dire	10e. Street and Number				10f. Zip		. 1.0				of What Cou		
	ns 23 must	Funeral	109 Fleetwood T	12. Was Dece	edent Ever in U	.S. 13.	Was Deced	209 dent of H		igin? (Sp	ecify Yes or No- Rican, etc.)		d Stat		
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Mar 3 🛣 Widowed 4 ☐ Divorced	If Ves Gir	2 📉 No ve		If Yes, spec 1 ☐ Yes 2				Rićan, etc.)		Black, White, ecify: Wh		
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d 2	a filed Il Hygi other /ent, t	Be Co	17. Father's Name (First, Middle,	Last)		_ Boar	1 0113		18. Mothe	er's Name	e (First, Middle, i				
ylar	should be filed withir nd Mental Hygiene. marked other than imatic event, the Me	TO E	William Bird Ga								Charlot				
Maryland 21215-0036	s 1 and 2 should be fill f Health and Mental H Item 27 is marked oth other traumatic even		19a. Informant's Name/Relations Barbara J. Hopk		ter		_				al Route Number			p Code) 2091(	1
	s 1 an of Heal item 2 other		20a. Method of Disposition		20b. F	Place of Disponentery, cre	sition (Nan	ne of			Silver		ion - City or T		
imo	Pages ment of I ant: if ite ury or of		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State Fa	irfax rk	Memor	ial		2/4/2	2008	Fairf	ax, Vi	rginia	a
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service	rioensee	M0095	$\mathbf{z} = \begin{bmatrix} \frac{2}{\mathbf{F}} \end{bmatrix}$	<sup>2. Name an</sup> <b>airfa</b>	id Addre: x Me	moria	al Fu	ıneral H Fairfa	ome x, VA	2203	32	
		2007	23a. Part. Enter the disease, o shock, or heart failure. List	complications that of only one cause on e	ach line.			-					=0.00	Approxima Interval Be Onset and	tween
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	Examiner		O	bue to	(or as a conseq	delice oi).									
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a conseq	uence of):									
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760,	# % e	calE		d											
( 68	ertificating physics as the	Medi	IF FEMALE:												
Box	death certificate be attending physic	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live t	come pf pregna pirth 2  Feta nant at time of d	al death 3[	⊒Ectopic pr ⊒ Other <i>(</i> sp		/			23d	. Date of delive Month	very Day	Year
P.O.	at the de by the a tached	hysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9☐Unkn		leatii J									
ds, P	ss that		Part II. Other significant conditi	ons contributing to de	eath but not res	ulting in the u	nderlying ca	ause giv	en in Part I	l.	23e. Did to		contribute to		
or Vital Records,	aw require s been sig 2 should b	Completed by									24a. Was a		4b. Were aut	opsy findings	available
R	The fav	Com		_		,					autops perfor 1∐ Yes	med?	death?	ompletion of o 2 □ No	cause or
Vita	sician: Th certificate irector, pag	Be	25. Was case referred to medica examiner?	Hospital:				Oth	or:	_	h (Check only or				
o	g Physer this eral di	n: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date	Inpatient 2  of Injury	28b. Time o		8c. Injur Worl	4 649		me 5 Residence 128d. Describe he			ify)	
sion	ending Path. or: After he funer	atio	1 ☑ Natural 5 ☐ Pendir 2 ☐ Accident investi	gation	th, Day Year)	Injury	М		Yes 2	No					
Division	i or Atteno after death Director: I in by the I	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ained   200, Place	of injury - At he ng, etc. (Specif		eet, factory	, office			28f. Location (Si City or Town		lumber or Rui	ral Route Nur	nber,
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	To the within 2 To the complet	Me	29b. Signature and title of certifie	n D					e number	. 0			igned (Month		
	0		1				"	,	601º				01-0		
,			30. Name and address of person  TAHMINAK.AI		se of death (Iten	n 23a) (Type,	Print)	D. C	= 54	(IFF	27 5	Lven	Spar	e Mn	205
	Sta	te	31. Date filed (Month, Day, Year)	32.	egistrar's Signa	ature	P			/-	27, Sz			1.19	2016
	Registr	rar	FEB 0 1	2008	Men 1	K A	Market !	,							

DHMH 17 Rev 1/2001

		For State	State	of Marylar	•	artment of I rtificate of		and Mental Hy	-	2000	01.522
	_	Registrar  1. Decedent's Name (First, Middle	. Last)			Tuncate of	Deain	2. Date of D	Reg. No	7000	3. Time of Death
Physi			illie Per	rv Sr				Month Januar	Day	Year 2008	10:10 AM
/Med Exam		4a. Facility Name (If not institution				4b. City, Town,	or Location			County of Death	10.10
		#2 Cameron Grov	e Blvd.	#104		Upper	Mar1b	oro	F	Prince G	eorge's
Funera		5. Social Security Number	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs.	• • •	If Under 1 Year Months Days		24 Hrs. 8. Date of B Min. (Month, D	irth	9. Birthp	place (State or Foreign
Directo	or	241-62-8821 Usual Residence of Decedent		67	Yrs.			May 25	, 194	0 Rich	Square, NC
/land ow at		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation				1	10d. Inside City Limits
Many a-f sh ified	ţ	MD Prince	George'	s t	Upper N	Marlboro					1 v Yes 2 No
th the or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Cour	ntry?
If I I I I I I I I I I I I I I I I I I		#2 Cameron Gro				207				U.S.	
er de items ner m	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	Armed F		l.S.   13.	Was Decedent of I If Yes, specify Cub	Hispanic Ori oan, Mexica	igin? (Specify Yes or N n, Puerto Rican, etc.)	0-	<ol> <li>Race - Americ Black, White,</li> </ol>	etc.
Irs aft	by F	3 ☐ Widowed 4 ☑ Divorced	If Yes, G	s 2 <b>⊡</b> No Give Dates:		1 ☐ Yes 21X No	Specify:			Specify.	rican- rican
2 hou 2 hou artura ical E		15. Decedent	's Education	A)		dent's Usual Occu			16b. Kir	Allie nd of Business/In	
thin 7	Completed	(Specify only highes Elementary/Secondary (0-12)		(1-4or 5+)	life.	kind of work done DO NOT use retire	auring mos ed)	at of working			
ed will ygien ygien t, the	ြင္ပ	12			Maste	r Barber				Private	!
be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle,	,					er's Name (First, Middle		Surname)	
hould d Mer narke	은	John Thomas P  19a. Informant's Name/Relationsl			10b Maili	ng Address /Stree		<b>llie Majett</b> er or Rural Route Num		r Taura Ctata Zir	- Code)
id 2 slith and 17 is r		McCoy C. Perr						y, Bowie, N			Code)
permit Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. The hours after death with the Marylan Important: If frem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition	y / 50II	20b. F		osition (Name of matory or other pla		Date Date		cation - City or To	own, State
Page: lent o nt: If		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		II State		amily Cer	1	2/1/2008	Rick	n Square	NC
mit.	ouce.	21. Signature of Funeral Service		+144_1				y McGuire F	unera	al Servi	ce, Inc.
	8	Undre	Ihom	pson	7	400 Georg	g <b>ia</b> Av	7e., N.W. W	ashir	ngton, D	.C. 20012
Physicial / Medica Examine physician and physician and the prinal-transit	al	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate bause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Black Due to  b. Smok Due to	ider Can o (or as a consec	quence of):	31	14/4-17/10-74				Interval Between Onset and Death
The law requires that the death certificate the has been signed by the attending physicage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 □Live	utcome pf pregna birth 2 ☐ Feta gnant at time of c nown	al death 3[	□Ectopic pregnand □ Other (specify) _	ey .		2	23d. Date of delive Month	ery Day Year
s tha	by P	Part II. Other significant condition	ns contributing to	death but not res	sulting in the u	ınderlying cause gi	ven in Part I	. 23e. Did	tobacco u	se contribute to t	he cause of death?
equire en sig		Hyperglycemia	1					1X	Yes 2[	∏No 3∏Prot	bably 4 Unknown
has be	ple	Hypothyroid						24a. Wa	s an opsy	24b. Were auto	opsy findings available impletion of cause of
hysician: The kins certificate ha	Completed	Skin Ulcers							formed?	death? 1 ☐ Yes	2 □ No
iclan sertifii ector,	Be	25. Was case referred to medical examiner?	Hoenital:			Lor	nor:	e of Death (Check only			
Phys rat dir	٦.	1 ☐ Yes 2 ☑ No 27. Manner of Death	' 1L	Inpatient 2 ☐ e of Injury	ER/Outpatie	IK SLIDOA	4 🗀 Ni	ursing Home 5 X Res			fy)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director;	Certification:	1 X Natural 5 ☐ Pendin 2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	g (Mo	onth, Day Year)	Injury ome, farm, st	Wo	rk?`` ]Yes 2⊟ —	No 28f. Location		d Number or Rura	al Route Number,
ne Hospite 124 hours e Funeral letely filled	Medical C	29a. Certifler 1 X Certifyin (Check only one) 2 Medical	Examiner: On the	he best of my kno basis of examina unner stated.	owledge, deat ation and/or in	th occurred at the to	ime, date ai opinion, dea	nd place, and due to the ath occurred at the time	e cause(s) e, date and	and manner as s I place, and due t	stated. to the cause(s)
To th within To th comp	Me	29b. Signature and title of certifier				29c. Licen			29d. Dat	e signed (Month,	Day, Year)
1		1 Mm	MD			00	057	1518	1/	30/08	
•		30. Name and address of person				Print)					
		Hien Nguyen,				Ave., N.I	E. Ten	mple Hills,	MD		
Poris	State	31. Date filed (Month, Day, Year)		Registrar's Signa	ature A	anti 1					

DHMH 17 Rev 1/2001

/Medical

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Medical

State Registrar 1 - For State Registr 1. Decedent

Physician

/Medical

**Examiner** 

Director

To Be Completed by Funeral

**Funeral** Director

Doris Amelia Peddicord  4a. Facility Name (If not institution, give street and number)  14217 Dav Road  5. Social Security Number 578-24-8509  Usual Residence of Decedent 10a. State Maryland Montgomery  10b. County Maryland Montgomery  10c. City, Town or Location Rockville  10f. Zip Code 20850  11. Marital Status 1	Feb 6, 1923 Mary  Teb 6, 1923 Mary  Tog. Citizen of What Could United State  Ify Yes or Nocican, etc.)  Italian and the state of Black, White Specify:  White Montgomery Public School Montgomery Public School Montgomery  Public Montg	ry hplace (State or Foreign untry) yland  10d. Inside City Limits 1
4a. Facility Name (If not institution, give street and number)  14217 Dav Road  5. Social Security Number 5. Social Security Number 6. Sex 1 M 2 XF 84 Yrs.  1 Months Days Hours Min.  10a. State 10b. County Maryland Montgomery  10c. City, Town or Location Rockville  10d. Zip Code 20850  11. Marital Status 1 Never Married 2 Married 3 Wirdowed 4 Divorced 1 Yes, Sign No Year or Dates:  1 Secent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+) 2  1 Secretary  1 S	January 29, 2008  4c. County of Death Montgomer  B. Date of Birth (Month, Day, Year) Feb 6, 1923  10g. Citizen of What Coulombre Coulomb	7:45 PM  h  ry  hplace (State or Foreign  yland  10d. Inside City Limits  1 Yes 2 No  untry?  tes  rican Indian, e, etc.  ite  industry  County  county  county  Town, State
4a. Facility Name (If not institution, give street and number)  14217 Dav Road  5. Social Security Number  5. Social Security Number  6. Sex  1 M 2 XF  84 Yrs.  1 Months Days Hours Min.  10a. State  10b. County  Maryland  10c. City, Town or Location  Rockville  10d. Zip Code  20850  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  2 College (1-4or 5+)  2 Secretary  15a. Decedent Street and Number or Hural  Harold U. Peddicord (Husband)  14217 Dav Road, Rockvil  14217 Dav Road, Rockvil  15a. Decedent's Education  (Give kind of work done during most of working life. Do Not use retired)  Secretary  15b. Mailling Address (Street and Number or Hural  14217 Dav Road, Rockvil  20a. Method of Disposition  15g Burial 2 Cremation 3 Removal from State  4 Donators  15g Burial 2 Cremation 3 Removal from State  4 Donators  16g Burial 2 Cremation 3 Removal from State  16g Decedent's Cremation (Name of Campetery, General Place)  16g Decedent's Cremation (Name of Campetery, General Place)  16g Burial 2 Cremation 3 Removal from State  16g Decedent's Cremation (Name of Campetery, General Place)  16g Decedent's Cremation (Name of Campetery, General P	4c. County of Death Montgomer  3. Date of Birth (Month, Day, Year) Feb 6, 1923  10g. Citizen of What Cou United Stat ify Yes or No- ican, etc.)  14. Race - Amer Black, White Specify: White Montgomery Public School First, Middle, Maiden Surname) onred  Route Number, City or Town, State, Zi Lle, MD 20850  te 20c. Location - City or Tarry 2,	h ry hplace (State or Foreign untry) yland  10d. Inside City Limits 1
Social Security Number  578-24-8509  June 1	3. Date of Birth (Month, Day, Year) Feb 6, 1923  10g. Citizen of What Coulombre United State 14. Race - American, etc.)  16b. Kind of Business/In Montgomery Public School First, Middle, Maiden Surname) onred  Route Number, City or Town, State, Ziele, MD 20850  te 20c. Location - City or Tarry 2,	Inplace (State or Foreign unity) yland  10d. Inside City Limits 1  Yes 2 No unity?  tes rican Indian, e, etc.  ite Industry County Dools  Town, State
State   10b. County   10c. City, Town or Location   10d. Zip Code   20850   1   Marital Status   10b. County   10c. City, Town or Location   10d. Zip Code   20850   1   Marital Status   12b. Was Decedent Ever in U.S. Armed Forces?   1   Yes. 2   Zip No   1   Yes. 3 pecify Cuban, Mexican, Puero R   1   Yes. 2   Zip No	3. Date of Birth (Month, Day, Year) Feb 6, 1923  10g. Citizen of What Coulombre United State 14. Race - American, etc.)  16b. Kind of Business/In Montgomery Public School First, Middle, Maiden Surname) onred  Route Number, City or Town, State, Ziele, MD 20850  te 20c. Location - City or Tarry 2,	Inplace (State or Foreign unity) yland  10d. Inside City Limits 1  Yes 2 No unity?  tes rican Indian, e, etc.  ite Industry County Dools  Town, State
Usual Residence of Decedent   10b. County   10c. City, Town or Location   Rockville	Teb 6, 1923 Mary  10g. Citizen of What Could United State  If y Yes or Nocican, etc.)  14. Race - American, etc.)  16b. Kind of Business/ly  Montgomery  Public School  First, Middle, Maiden Surname)  Onred  Route Number, City or Town, State, Zince, MD 20850  te 20c. Location - City or Tary 2,	yland  10d. Inside City Limits  1  Yes 2 No  untry?  tes  rican Indian, a, etc.  ite  Industry  County  cols
10b. County   Montgomery   10c. City, Town or Location   Rockville	United Stat  United Stat  I4. Race - Amer Black, White Specify: Whi  I6b. Kind of Business/l Montgomery Public Scho  First, Middle, Maiden Surname)  Onred  Route Number, City or Town, State, Zi Le, MD 20850  te 20c. Location - City or Tary 2,	1 ☐ Yes 2 ▼ No untry?  tes rican Indian, e, etc.  ite Industry County County County Town, State
Maryland   Montgomery   Rockville	United Stat  United Stat  I4. Race - Amer Black, White Specify: Whi  I6b. Kind of Business/l Montgomery Public Scho  First, Middle, Maiden Surname)  Onred  Route Number, City or Town, State, Zi Le, MD 20850  te 20c. Location - City or Tary 2,	1 ☐ Yes 2 ▼ No untry?  tes rican Indian, e, etc.  ite Industry County County County Town, State
10f. Zip Code   20850   2085	United Stat  United Stat  I4. Race - Amer Black, White Specify: Whi  I6b. Kind of Business/l Montgomery Public Scho  First, Middle, Maiden Surname)  Onred  Route Number, City or Town, State, Zi Le, MD 20850  te 20c. Location - City or Tary 2,	tes rican Indian, e, etc.  ite Industry County Dools
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12. Was Decedent Ever in U.S. Armed Forces?   12. Was Decedent Ever in U.S. Armed Forces?   12. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto R If Yes, Specify Cuban, Mexican, Puer	ify Yes or No- ican, etc.)  14. Race - Amer Black, White Specify: Whi 16b. Kind of Business/It Montgomery Public Scho First, Middle, Maiden Surname) onred  Route Number, City or Town, State, Zi 1e, MD 20850  te 20c. Location - City or Tarry 2,	ican Indian, e, etc.  ite Industry County Dols  Town, State
1   Never Married   2   Married   1   Yes   2   No   If Yes   Give Year or Dates:   1   Yes   2   2   No   Specify:	Black, White Specify: White Montgomery Public Scho First, Middle, Maiden Surname) Onred Route Number, City or Town, State, Zi Lle, MD 20850  te 20c. Location - City or Tarry 2,	ite industry County Dols
15. Decedent's Education (Specify only highest grade completed)   16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)   Secretary   17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Last)   19b. Mailing Address (Street and Number or Bural 14217 Dav Road, Rockvi.   19b. Mailing Address (Street and Number or Bural 14217 Dav Road, Rockvi.   19b. Mailing Address (Street and Number or Bural 14217 Dav Road, Rockvi.   19b. Mailing Address (Street and Number or Bural 14217 Dav Road, Rockvi.   19b. Mailing Address (Street and Number or Bural 14217 Dav Road, Rockvi.   19b. Mailing Address (Street and Number or Bural 14217 Dav Road, Rockvi.   19b. Mailing Address (Street and Number or Bural 14217 Dav Road, Rockvi.   19b. Mailing Address (Street and Number or Bural 14217 Dav Road, Rockvi.   19b. Mailing Address (Street and Number or Bural 14217 Dav Road, Rockvi.   19b. Mailing Address (Street and Number or Bural 14217 Dav Road, Rockvi.   19b. Mailing Address (Street and Number or Bural 14217 Dav Road, Rockvi.   19b. Mailing Address (Street and Number or Bural 14217 Dav Road, Rockvi.   19b. Mailing Address (Street and Number or Bural 14217 Dav Road, Rockvi.   19b. Mailing Address (Street and Number or Bural 14217 Dav Road, Rockvi.   19b. Mailing Address (Street and Number or Bural 14217 Dav Road, Rockvi.   19b. Mailing Address (Street and Number or Bural 14217 Dav Road, Rockvi.   19b. Mailing Address (Street and Number or Bural 14217 Dav Road, Rockvi.   19b. Mailing Address (Street and Number or Bural 14217 Dav Road, Rockvi.   19b. Mailing Address (Street and Number or Bural 14217 Dav Road, Rockvi.   19b. Mailing Address (Street and Number or Bural 14217 Dav Road, Rockvi.   19b. Mailing Address (Street and Number or Bural 14217 Dav Road, Rockvi.   19b. Mailing Address (Street and Number or Bural 14217 Dav Road, Rockvi.   19b. Mailing Address (Street and Number or Bural 14217 Dav Road, Rockvi.   19b. Ma	White the state of	County County Cols  Cip Code)  Town, State
Comparison of the properties	First, Middle, Maiden Surname)  Proposed  For Middle, Maiden Surname)  For Middle, Middle, Maiden Surname, Middle,	County County Cols  Cip Code)  Town, State
Elementary/Secondary (0-12)  College (1-4or 5+)  2  17. Father's Name (First, Middle, Last)  Vilson Briggs  19a. Informant's Name/Relationship (Type, Print) Harold U. Peddicord (Husband)  19b. Mailing Address (Street and Number or Rural 14217 Dav Road, Rockvillarold U. Peddicord (Husband)  20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State 4  Donation 5  Other (Specify)  21. Signature of Funeral Service Licensed  22. Name and Address of Facility Devortory or the place of Disposition (Name of Cametery, Crematory, or other place) Forest Uak Cemetery  22. Name and Address of Facility Devortory or the place of Disposition (Name of Cametery, Crematory, or other place) Forest Uak Cemetery  22. Name and Address of Facility Devortory or the place of Disposition (Name of Cametery, Crematory, or other place) Forest Uak Cemetery  22. Name and Address of Facility Devortory or other place or Disposition (Name of Cametery, Crematory, or other place) Torest Uak Cemetery  22. Name and Address of Facility Devortory or other place or Disposition (Name of Cametery, Crematory, or other place) Torest Uak Cemetery  23a. I art1. Itn I in the disease, or complications that caused the demic. Do not enter the mode of dying, such as cardiac or Due to (or as a consequence of):	Public Scho  First, Middle, Maiden Surname)  Dinred  Route Number, City or Town, State, Zi  Lie, MD 20850  te 20c. Location - City or Tarry 2,	Town, State
18. Mother's Name   18. Mother's Name   18. Mother's Name   19. Instruction   19.	First, Middle, Maiden Surname)  onred  Route Number, City or Town, State, Zi  1e, MD 20850  te 20c. Location - City or Tary 2,	Town, State
Ison Briggs  19a. Informant's Name/Relationship (Type. Print)  Harold U. Peddicord (Husband)  19b. Mailing Address (Street and Number or Rural 14217 Dav Road, Rockvi  10a. Method of Disposition  1	Route Number, City or Town, State, Zi Lle, MD 20850 te 20c. Location - City or Tary 2,	Town, State
19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural  14217 Dav Road, Rockvi  14217 Dav Road, Rockvi  14217 Dav Road, Rockvi  14217 Dav Road, Rockvi  15g Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22a. Fart1. It in rine a sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or mendate dause (Final disease of condition resulting in death)  23a. Fart1. It in rine a sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or mendate dause (Final disease of condition resulting in death)  25c Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Route Number, City or Town, State, Zi. 1e, MD 20850  te 20c. Location - City or Tary 2,	Town, State
Harold U. Peddicord (Husband)   14217 Dav Road, Rockvi	1e, MD 20850 te 20c. Location - City or T	Town, State
Sequentially list conditions, and picked in linitate of learning in the initiate of events.   Sequentially list conditions, and initiated events.   Sequentially list conditions, at initiated, events.	ry 2,	
2008 21. Signature of Funeral Service Licansed 22. Name and Address of Facility DeVo 10 E. Deer Park Driv 23a. Fart1. Interview a sease, or complications that caused the desire. Do not enter the mode of dying, such as cardiac or lines are of condition resulting in death)  25. Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause (Disease or or injury hat initiated events)  26. Due to (or as a consequence of):	ry 2,	
22. Name and Address of Facility DeVol  10 E. Deer Park Driv  23a. art1. In Introduce a sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or mode, in legal, if fullure. List only one cause on each line.  Immediate gauss (Final disease of condition resulting in death)  a. Due to (or as a consequence of):	Garthersbur	ce. MD
23a. Fart1. If in ripline disease, or complications that caused the dense. Do not enter the mode of dying, such as cardiac or specific tripline. List only one cause on each line.  Immediate Gause (Final disease of condition resulting in death)  a. Due to (or as a consequence of):	ol Funeral Home,	- 6, 1
Immediate (Jause (Final disease of condition resulting in death)  Due to (or as a consequence of):	e, Gaithersburg,	MD 20877
Immediate Gause (Final disease of condition resulting in death)  Due to (or as a consequence of):	respiratory arrest,	Approximate Interval Between
Due to (or as a consequence of):  Sequentially list conditions, ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.		Onset and Death
cause. Enter Underlying Cause (Disease or injury hat initiated events c.		W 1 1 1 C
cause. Enter Underlying Cause (Disease or injury that initiated events c		
that initiated events c.		
Due to (or as a consequence of):		
d		
IF FEMALE:		
23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	23d. Date of deliver Month	very Day Year
1 □ Yes 2 □ No 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown		Day Tour
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?
	1 Yes 2 No 3 Pro	1.4
	24a. Was an autopsy 24b. Were aut	topsy findings available completion of cause of
	performed? death?  1 Yes 2 No 1 Yes	
25. Was case referred to medical examiner?	Check only one)	
1 Yes 2 No Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Hom		cify)
1 Natural 5 Pending (Month, Day Year) Injury Work?	d. Describe how injury occurred	
2 ☐ Accident investigation   M   1 ☐ Yes 2 ☐ No   3 ☐ Suicide   6 ☐ Could not be determined determined determined investigation   28e. Place of injury At home, farm, street, factory, office   28e.		ral Route Number,

The law requires that the death certificate be executed To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death.

Vo the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran

25. Was cas examine 1 Yes 27. Manner o 1 Matu 2 ☐ Acci 3 ☐ Suic 4 Hom 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b.

29d. Date signed (Month, Day, Year)

nature and title of certifier

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOOME

31. Date filed (Month, Day, Year)

3-00732	- 51	Please Type or Print in Black Inde				ble.	
ames Penderg		- 10.10 J	tment of Health ficate of Death	and Mental F	Reg.  2. Date of Death		3. Time of Death
Physici ledical Exami		James Albert Pendergraft, Jr.			Month D January 26,	Day Year 2008	2010 hrs
		4a. Facility Name (it not institution, give street and number) University Hospital	4b. City, Tow Baltimor	vn, or Location of Dea re		4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 445-70-9875 1X M 2 F 36		1 Year   If Under 24H Days Hours Mi	· ·	(MM/DD/YYYY) 9. Birth Foreign Cou	
Jaryland 28a-f show any 1 at once.	or	Usual Residence of Decedent  10a. State	own or Location Chincotea	ague	-		10d. Inside City Limits 1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 8253 Seaweed Drive	10f. Zip Co	23336	10g.	. Citizen of What Count US?	-
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygies after a 77 is marked other than "natural", or items 23a or 28a-f 5the matic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 X Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	If Yes, specify C	of Hispanic Origin? (Cuban, Mexican, Puer		14. Race - Americ White, etc. Specify: W	an Indian, Black, Thite
iours af natural' xamine	ed by	or Dates:	6a. Decedent's Usual Octubring most of working	cupation (Give kind o		6b. Kind of Business/In	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hemore of Pheth and Mental Hygene. The filen 27 is marked other than "no or other traumatic event, the Medical E.	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	Cable Tec	chnician		Coastal S	Satellite
215-1 e filed tal Hyg ked oth	Be C	17. Father's Name (First, Middle, Last)  James Pendergraft, Sr.			ne (First, Middle, Ma ara Hamilt		
21; should be nd Men is mar	Tof	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (	(Street and Number o	r Rural Route Numbe	er, City or Town, State,	
and 2 sho lealth and tem 27 is		James Pendergraft, Sr/Father  20a. Method of Disposition  20b. Pla	ace of Disposition (Name	of cemetery	Date 1	atfield, MC 20c. Location - City or	0 64458 Town, State
more		1 Burial 2 Cremation 3 X Removal from State OCCO	matory or other place) hannock Cre	matory   Ja	n 31, 2008	Exmore, V	A
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within popartment of Health and Mental Hygiene. Important: If item 27 is marked other the injury or other traumatic event, the Med		21. Signature of Funeral Service Licensee	Harrand Ad Barranco 495 Gov.	dress of Facility & Sons, I Ritchie	P.A. Seven	rna Park Fu rna Park, M	neral Home D 21146
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Defailure. List only one cause on each line.					Approximate Interval Between Onset and
kaminer		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a consequence of):					Death
	er	Sequentially list conditions,					
	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated					
xecuted n and - transit		events resulting in death) Last  Due to (or as a consequence of):  d.					
9 E E	dical	UNPENDED AMENDED					
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be exhibit at hours after death.  The Law of the Funeral Director: After this certificate has been signed by the attending physician upletely filled in by the funeral director, page 2 should be detached for use as the burial.	sician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown Company Likeways	2 Fetal death	3 Ectopic preg	nancy	23d. Date of delivery Month D	ay Year
D. B( t the de by the	Phy	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying ca	ause given in Part I.	23e. Did toba	acco use contribute to t	the cause of death?
s, P.C nires that signed	ed by	<u></u>			1 Yes	2 ✓ No 3 Prob	
Records The law requested has been page 2 shoul	Completed				24a. Was an autopsy perform	y prior to coned? death?	topsy findings available ompletion of cause of ss 2 No
ital Recionant The scriticate rector, page	Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient 2 Ef	,	Place of Death (Chec		S - Other	
in of Vital Recuding Physician: The h. After this certificate is funeral director, page	ion: To	27. Manner of Death 28a. Date of Injury (Month Day Year)	2050 1	2. Injury at Work?  1 Yes 2 No	28d. Describe ho	desidence 6 Other ow injury occurred exed object collisio	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Certification:	2 V Accident Investigation 3 Suicide 6 Could not be determined (Specify) street	A		or Town, Sta	reet and Number or Ru ate) uth of Fisher Rd, Chi	
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, one) 2 Medical Examiner: On the basis of examination and and manner stated.	, death occurred at the tin l/or investigation, in my or	me, date and place, a pinion, death occurre	nd due to the cause( d at the time, date an	(s) and manner as state and place, and due to the	ed. e cause(s)
To To COU	Me	29b. Signature and title of certifier		icense number		29d. Date signed (Mor	•
		Kote Weller		D.C.M.E.		January 27, 2008	
ditte		Name and address of person who completed cause of death (Item 23 Patricia Aronica-Pollak MD. Assistant Medical Ex	·	nn Street, Baltim	ore, MD 21201		
	tate	31. Date filed (Month, Day, Year) 2008 32. Resistrar's Signature	* books				
Regis	पदा	Comment of the control of	AT ASSESSED				

Registrar DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Physician

/Medical

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

6. Sex

1 M 2 F

3113 Beards Point Rd.

10b. County

Edith Proctor

5. Social Security Number

10a. State

220-30-5261

Usual Residence of Decedent

Man, a-f sh	Dell	혅	Maryland Anne Arundel	Davi	dsonville			1 ∐Yes 2 <b>X</b> No			
th the	iou a	jre	10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?				
ith wil	nst D	la	3113 Beards Point Rd.		21035		USA				
er dea	E	nue	11. Marital Status 12. Was Deceder Armed Forces	s?	13. Was Decedent of Hispa If Yes, specify Cuban, N	nic Origin? (Specify Yes or No Nexican, Puerto Rican, etc.)	- 14. Race - Ame Black, White				
ally idilic K. I.K. 13-0030 should be filed within 72 hours after death with the Mary nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f sh.	Exami	d by Funeral Director	1 □ Never Married 2 □ Married 1 □ Yes 2 15 If Yes, Give Year or Dates		1 □ Yes 2 □ No S	pecify:	Specify: B1	ack			
12 h 27 h	edica	ete	15. Decedent's Education (Specify only highest grade completed)	16a. I	Decedent's Usual Occupatior (Give kind of work done durin life. DO NOT use retired)	n ng most of working	16b. Kind of Business/	*			
within lene.	ne m	Completed	Elementary/Secondary (0-12) College (1-4o		Nursing Aid		Crownsvi Hospital				
al Hyg	vent,	Be C	17. Father's Name (First, Middle, Last)			Mother's Name (First, Middle,		-			
ally allo 2 12 2 should be filed withi and Mental Hygiene. Is marked other than	arice	2	George Sollers		A	nna Octiva I	Holt				
iges 1 and 2 should be filed within 72 hours after death with the Mary at 6 Hearth and Mental Hygiene. If tem 27 is marked other than "natural", or items 23a or 28a-f sh	er traum		19a. Informant's Name/Relationship (Type. Print) Sylvia Belt(Daughter)	88	6 Marengo S	Number or Aural Aoute Numb t. Annapolis		,			
Pages 1 and 2 search of Health ar	us or our		20a. Method of Disposition  1 ☒ Burial 2 □ Cremation 3 □ Removal from Stat  4 □ Donation 5 □ Other (Specify)		Disposition (Name of y, crematory or other place) and Veteran	Date 2-5-08	20c. Location - City or Crownsvil				
permit. Pages Department of Important: If I	once.		21. Signature of Funeral Service Licensee	M00482	1	t. Annapolis	-				
150,00	S.		23a. Part1. Enter the dilease, or complications that caus shock, or heart fillure. List only one cause on each	ed the death. Do notine.	ot enter the mode of dying, s	uch as cardiac or respiratory a	rrest,	Approximate Interval Between			
Physic			Immediate Cause (Final disease or condition resulting in death)	RKINSD	20 24	€13 E		Onset and Death			
/Medi Exami	200			as a consequence o							
, i		-e	Sequentially list conditions, if any, leading to immediate b. Due to (or a	as a consequence o	f):						
cuted	100	Examiner	Sequentially list conditions, if any, leading to immediate cause. E nor Underlying Cause (Disease or injury that initiated events								
e exe		Ĕ	resulting in death) Last  Due to (or a	as a consequence o	f):						
cate b	2 2	dica	d								
sician: The law requires that the death certificate be executed certificate has been signed by the attending physician and	cried to use as	Physician/Medical		2 ☐ Fetal death at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of del Month	ivery Day Year			
s that	agen	by Ph	Part II. Other significant conditions contributing to death	but not resulting in	the underlying cause given in	Part I. 23e. Did t	obacco use contribute to	the cause of death?			
aquire:	200	ed b	DEMENTIA			10	Yes 2⊠No 3⊟Pi	robably 4 Unknown			
he law re has bee	ige 2 age	Completed				24a. Was auto perfo 1  Yes	rmed?   death?	atopsy findings available completion of cause of			
an: T	, 50	Be	25. Was case referred to medical	2 X No 1 Yes	1 ☐ Yes 2 ☐ No						
nysici nis ce	5	2	examiner?  1 Yes 2 No Hospital: 1 Inpa	itient 2 ER/Out	100	4 ☐ Nursing Home 5 ☐ Resi		cify)			
nding Pl			27. Manner of Death  1 ∰Autural 5 □ Pending 2 □ Accident investigation 28a. Date of Ir (Month, D	njury 28b. Ti Day Year) In	jury Work?	28d. Describe	now injury occurred				
lor Atter	6	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or R City or Town, State)								
To the Hospital or Attending Phys within 24 hours after death.	areny illies	29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Mon.									
To the To the		Be	29b. Signature and title of certifier		29c. License nu	mber	29d. Date signed (Mont	h, Day, Year)			
		1			0234	-57	Ina 28,00	008			
Ja			30. Name and address of person who completed cause of Anthony Caputo 139	death (Item 23a) (T		Rd. Annapolis,					
Re	Stat gistra		1.0.11	strar's Signature	had.	1011111111					
DHMH 17 Re	v 1/20	01		~~~ <u>//</u>	Marin						
					ORIGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

7. Age (In yrs. last birthday)

90 Yrs.

10c. City, Town or Location

4b. City, Town, or Location of Death

Davidsonville

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

2. Date of Death

8. Date of Birth (Month, Day, Year) June 21 1

January 28 2008

4c. County of Death

1917

Anne Arundel

6:45 A M

Birthplace (State or Foreign Country)

Mary1and

10d. Inside City Limits

			1 - For State Registrar	State of Maryla			ealth and N	Mental Hygie	nen 0 8	04526	
	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, L AR / G / 4a. Facility Name (If not institution, g	ive street and number)	PAR	KER	Location of Death	2. Date of Death Month	Day Year Z 9 68 4c. County of Death WURCES	. /	
	Funeral Director		5. Social Security Number 6.  182 26 7594  Usual Residence of Decedent			f Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye		nplace (State or Foreign untry)	
	ith the Marylan or 28e-f show	Olrector	10a. State 10b. County  Md WORC  10e. Street and Number	ester (	City, Town or Locat	ion 10f. Zip Code		10g.	. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☐ No untry?	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. item 27 ie marked other then "naturel", or iteme 23a or 28e-1 show other treumatic event, the Macincal Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	If Ye		spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	States ican Indian, o, etc.	
21215-0036	ed within 72 hou giene. er then "nature the Madical E	Completed	15. Decedent's (Specify only highest g	Education	(Give kind life. DO	t's Usual Occupa d of work done do NOT use retired)	tion uring most of work	ing 16t	b. Kind of Business/I	ndustry	
Maryland	2 should be filed withir and Mental Hygiene. ie marked other then eumatic event, II e M	To Be (	17. Father's Name (First, Middle, Las	iend	19b. Mailing A		mar				
Baltimore, N	0 0		CharSeka Park  20a. Method of Disposition  1 Dourial 2 Cremation 3  4 Donation 5 Other (Spec	20b.	Place of Disposition cometery, cremato	on (Name of		i	Location - City or T	5 2 Fown, State Vic. 2330 \	
Balt	permit. Pag Department Important: i eny injury o		21. Signature of Funeral Service Lice  23a. Part1. Enter the disease, or conshock, or heart failure. List only	huntor  Inplications that caused the de	23	217/ W	of Facility W NRfrn, such as cardiac	Rl	Accompo	Approximate Interval Between	
	cate be executed / Medical Example / Medical und phuiai-transit the prirational file phuiai-transit cause / Medical phuiai-t	Ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consection of the consection	equence of):	<i>√</i> €	of b.	na		Onset and Death	
P.O. Box 68	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 3 □ No 9 □ Unknown	23c. If yes, outcome of preg. 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	tal death 3 ⊟Ect	opic pregnancy her (specify)			23d. Date of deliver Month	very Day Year	
ords, P	w requires that been signed t should be det	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						co use contribute to the cause of death?		
		Be Completed	25. Was case referred to medical				26. Place of Death	24a. Was an autopsy performed 1 Yes (Check only one)	prior to co	opsy findings available ompletion of cause of No	
o o	ling Phys	2	examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Other  28c. Injury a Work?  1 □ Ye	at Nursing Hol	me 5 Residence 28d. Describe how in	Other (Speci		
É	Hospital or Attend 4 hours after death Funerel Director: tely filled in by the f	Certification:	3 Suicide 6 Could not I 4 Homicide determined	building, etc. (Spec	cify)			City or Town, St	,		
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one)  29b. Signature and title, of certifier	hysician: To the best of my kr miner: On the basis of examin and manner stated.	nowledge, death occurrence and/or investi	gation, in my opin	nion, death occurre	ed at the time, date	e(s) and manner as s and place, and due t Date signed (Month,	to the cause(s)	
	- > - ō		1 Joch In	completed cause of death (Ite	am 23a) (Tune Print	Das	8057	(ms)	1/3/1	8	
R	A 5 Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	11 Coa	istal	thy,	)cean (	ity Mi	21842	
	Registr	_	EED N A	2000	4	100	)				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Eloise 01 2008 38 /Medical 4b. City, Town, or Location of Death County of Death Facility Name (If not institution, give street and number) Examiner Peninsula Regional 9. Birthplace (State or Foreign Country), Date of Birth (Month, Day, **Funeral** Months Hours 1 □ M 2 K F MARYLAND 220-26-9031 1930 3-Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No (1) E/MAR Wicomico Funeral Director N)ARUL AND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A 21875 8628 Shadow LANE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. once. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify Be Completed by Black 3 Widowed 4 □ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) WONE Elementary/Secondary (0-12) omestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ChristophER + URNEll HANDU ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) - DAUGHTER DEMAR CLARICE Shad DW LA. 8628 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State Spring hill Conedens -2-08 HEDRON 21. Signature of Funeral Service Licenses Salis M Stewar STEWAR 158 FUNERA. 10 B DOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician; The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) cate has been signed by the attending physician a page 2 should be detached for use as the burial Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2X No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 2 K ER/Outpatient 3 □ DOA 1 Inpatient 1 🗌 Yes After this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30-200 lomk 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Division St. SAlisbury Vara Anupama 31. Date filed (Month, Day, Year) State FEB 01 Registrar

5

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Robert J. Patterson 800 South Talbot Street, St. Michaels, MD 21633

gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEB 1 2 2008

29c. License number D0057908

			1 - For Registrar	State of I	Marylan				ealth a	and Me	ental Hy	giene	UU	8	0452	9
			1. Decedent's Name (First, Middle, L	ast)						2	2. Date of D	eath Day	,	Year	3. Time of Deat	h
	Physici /Medio Examir	al	Edna Rebecca Rigg		θr)		4b. City,	Town, or	Location		Januai	cy 31		08	12:20	<u>M</u>
			Northampton Mano					deric		2411			eder			
	Funeral Director		5. Social Security Number 6. 219-01-2334	Sex 7. 1 ☐ M 2 🗶 F	Age (In yrs.	(ast birthday)		r 1 Year Days	If Under Hours	Min.	B. Date of Bi (Month, D	ay, Year)		Cour	place (State or Forentry) 11and	əign
	g ,		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	cation							1	IOd. Inside City Lin	nits
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Deperment of Health and Mental Hyglene. Important: if Item 27 is marked other than "naturel', or Items 23e or 28e-f ehow any injury or other traumatic event, the Mailfiel Examinant into the indiffied at Once.	to	Maryland Frederi	ck		erick	oution,								1 ☐ Yes 2 🛣	, No
	h the	Director	10e. Street and Number				10f. Zi	p Code				10g. Cit	izen of W	hat Cou	ntry?	
	th wil	a	6886 Buckthorn Co					703				USA				
	tems tems	Funeral	11. Marital Status	12. Was Decede Armed Force	es?	.S. 13. V	Was Dece f Yes, spe	dent of Hi orify Cuba	ispanic Ori n, Mexicar	gin? (Spec 1, Puerto R	ify Yes or Nican, etc.)	0-		- Ameno c, White,	can Indian, etc.	
920	urs afte	Þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date		1	1 ☐ Yes	2 <b>X</b> ) No	Specify:				Specify:	Whit	e	
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d 2	filed Hygie other		17. Father's Name (First, Middle, Las	st)		Homem	akei		18. Mothe	er's Name	(First, Middl	1				
an an	Mental Mental rked tic ev	To Be	John William Shi	pley					Cora	M. R	hineha	art				
Maryland	2 should have and have rauma		19a. Informant's Name/Relationship	(Type, Print)				•			Route Num					
	Health Health tem 27 other t		John W. Riggleman  20a. Method of Disposition	n, son	20b. F	6886 Place of Dispo cemetery, cren	sition (Na	me of		Da	ate	20c. L	Mary ocation ·	Land City or T	21703 own, State	
ê E	Pages ent of nt: If I		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		ate	ascus				Feb 2 eterv	, 2008		scus	. Ma	ryland	
Baltimore,	Deperting Imports any Inju		21. Signature of Funeral Service Lic	ensee	,	22	. Name a	nd Addres	ss of Facili	tyMo1e	swortl	n-Wil	liam	s Fu	neral Ho 20872	me
	40 F 4 0		23a. Part1 Enter the disease, or co	mplications that call	ised the deat						amascı		laryı	and	Approximate Interval Between	
A. C.	Physician /Medical Examiner		shock, or heart failure. List on Immediate Osuse (Final disease or condition resulting in death)	a. <u>Acute</u> Due to (or	Rena1	Failu:									Onset and Death	
760,	te be executed ysician and e burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	с	r as a consec	quence of):										
O. Box 68	es that the death certificate be executed igned by the attending physician and be detached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown		h 2 ☐ Feta nt at time of c	aldeath 3□	Ectopic	pregnancy specify)	′				23d. Date Mor		very Day Year	
ds, P.O.	equires thet the sen signed by th tould be detache	d by Ph	Part II. Other significant conditions Dementia, Anemi		th but not res	sulting in the u	nderlying	cause giv	en in Part	l.					the cause of death	
Records,	elawi hesb je2st	Completed by									per	opsy formed?	6	rior to co	opsy findings avai ompletion of cause 2 \square	lable e of
Vital	ilcien: Th certificete rector, pag		25. Was case referred to medical						26. Plac	e of Death	(Check only	2 <b>∑</b> No ∕ one)	0   '	163	20 140	
Ę.	Physicien: this certific ral director,	To Be	examiner? 1 ☐ Yes 2 🔯 No	Hospital: 1 🗆 Inj	patient 2	] ER/Outpatier	nt 3 🗆 🛭	Oth	ier: 4∭ N	ursing Hon	ne 5∐Re	sidence	6 <b>□O</b> the	er (Spec	ify)	
o uo	fing After fune	tlon:	27. Manner of Death  1 X Natural 5 Pending 2 Accident investigat	28a. Date of (Month	Injury , Day Year)	28b. Time o Injury	f M	28c. Injur Wor	yat k? Yes 2.□		8d. Describ	e how inju	iry occurr	ed		
Division of	To the Hospital or Attending Physicien: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not 4 Homicide determine	be 28e. Place o	of Injury - At h g, etc. (Speci	nome, farm, sti ify)	reet, facto	ory, office		2		(Street a. own, Stat		er or Ru	rai Route Number,	
	he Hospi n 24 hour he Funari	ledical (	29a. Certifier 1 💢 Certifying (Check only one) 2 Medical Ex	Physician: To the base aminer: On the base and manne	is of examin	owledge, deat ation and/or in	h occurre	d at the tir on, in my o	me, date a ppinion, de	nd place, a ath occurre	and due to the	e, date an	nd place, a	and due	to the cause(s)	
	To the To the comp	ž	29b. Signature and title of certifier	d -	-	mD.	2	9c. Licens	e number			29d. Da	ate signed	d (Month	n, Day, Year)	
			D54636 January 31, 2008								2008					
	6		30. Name and address of person wi						1	1_ 35	1	1 01	701			
	C+	ate	Syed W. Haque, M 31. Date filed (Month, Day, Year)						ieric	K, Ma	ryrane	1 21	.701			
	Regist		FER	0 1 2008	Mentine	ature #	Sales .	1								

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend items 10b, 19a per inf g87/3-24-08 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 1820 obert February 2008 /Medical tc. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Medical Examiner Bayriew Baltimore If Under 1 Year | If Under 24 Hrs. Hopkins center 8. Date of Birth (Month, Day, Year) 4/23/1941 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min **№** M 2□ F 66 Yrs. Director MD 219-36-5613 Usual Residence of Decedent Queen Anne's 10a. State 10c. City, Town or Location 10d. Inside City Limits la or 28a-f show t be notified at Pondtown 1 ☐Yes 🌪 ☐ No Director MD Kent 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21620 permit. Pages 1 and 2 should be filed within 72 hours after death will Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b 223 Pinetree USA Rd Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Black 3altimore, Maryland 21215-0036 Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Laborer Local 199 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leon Roberts, Sr. Birdie Wilson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henora Virginia Roberts Virginia Roberts 223 PinetreeRd Chestertown, MD 21620 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
MT. Pleasant UM Date 20c. Location - City or Town, State 2/9/08 Pondtown, MD 4 □ Donation 5 □ Other (Specify) W. Annapolis, MD 21401 F.S. 821 21. Sign tur of Funeral Service Licensee lay (W00026) 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Increased Macranial **Physician** hour /Medical Due to (or as a consequence of): **Examiner** nemorry tracerebral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner and burial-trar Due to (or as a consequence of) P.O. Box 68760, led by the attending physician detached for use as the burial pe Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autonsy performe 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) venue Karen 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#8perFH2/1/08, EMW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 27, 2008 **Physician** 12:15 AM David Siegel /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Spring House Manor Care Bethesda If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day), Hours Min. Dec. 29, 1914 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** M 2□F 93 New York 577-20-8227 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at Bethesda Maryland Montgomery 1XYes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4925 Battery Lane 20814 United States filed within 72 hours after death was the Hygiene. "natural", or items 238 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes ② No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Retail Business Owner the permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important: If item 27 is marked other I any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Solomon Siegel Lena Apter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
222 Wort Francis Street, Aspen, CO 81611 19a. Informant's Name/Relationship (Type. Print) 323 West Francis Street, Aspen, CO Esther Pearlstone/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place).

George Cown University January 27 2008 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Washington, D.C. 2008 4 ☐ Donation 5 ☐ Other (Specify) Medical Center 21. Inature of uneral Service License 22. Name and Address of Facility Columbia Mortuary Services, P.A. 9013 Annapolis Road, Lanham, MD 20706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Prostata Immediate Cause (Final disease or condition resulting in death) Cancer Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed and -trans Due to (or as a consequence of): physician as P.O. Box 68760 Physician/Medical as t attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d Date of delivery 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by Peripherd Mascular Disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

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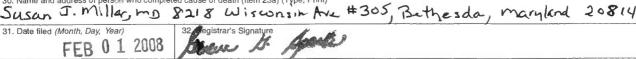
To the Funeral Director:
completely filled in by the f 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospita 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

2008 0 1

29b. Signature and little of certifier

31. Date filed (Month, Day, Year)



son who completed cause of death (Item 23a) (Type, Print)

To the h

29c. License number 3 5 5 7

29d. Date signed (Month, Day, Year) 2/01/2008

		1 - For State Registrer	State of Marylan		artment of H rtificate of L			jiene leg. No 0 0	8 04532		
Physic /Med		1. Decedent's Name (First, Middle, La:	Stame CARO	LINE	STARNER		2. Date of Dea Month	_	Year 6:10 P M		
Exami Funera	iner	4a. Facility Name (If not institution, given Carroll Lutheran  5. Social Security Number  6. S	Village Health	ast birthday,	Westm	Location of Death Linster  If Under 24 Hrs. Hours Min.	8. Date of Birth		of Death arroll  9. Birthplace (State or Foreign Country) MD		
Director		213-05-3832 Usual Residence of Decedent		/, Town or L					10d. Inside City Limits		
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TIOCE, IN Pages 1 and ant of Health at: If Item 27 y or other to		Carl Starner/son  P.O. Box 56 Butler, MD 21023  20a. Method of Disposition  P.O. Box 56 Butler, MD 21023  20b. Place of Disposition (Name of cemetery, crematory or other place)  P.O. Box 56 Butler, MD 21023  20c. Location - City or Town, State cemetery, crematory or other place)  Meadow Branch Cemetery 02/02/2008 Westminster, MD									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend line 17 per fd State of Maryland / Department of Health and Mental Hygiene aaco hlth dept 01/31/08 dlw 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 26 2008 0025 **Physician** January Adell Marie Smith /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Lothian 5037 Solomons Island Rd. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Apr 5 5. Social Security Number **Funeral** Months Days 81 Apr 1926 Mary1and 220-16-7384 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County or 28a-f show notified at 1 ☐ Yes 2 No Maryland Anne Arundel Lothian Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code d 2 should be filed within 72 hours after death with ith and Mental Hyglene.
7 is marked other than "natural", or items 23a or it man and on the man and man and man and man and man and a traumatic event, the Medical Examiner must be or USA 20711 5037 Solomons Island Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Mio 3altimore, Maryland 21215-0036 Specify. Specify: Black þ 3 XWidowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) Naval Academy 12th 0 Laundry Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Estep Pratt Cornelia Johnson ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health an Important: If Item 27 is any injury or other trau once. Lothian, Md. 20711 Kenneth Smith Jr. (Son) 5037 Solomons Island Rd. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion UMc Cem 2-2-08 Lothian, Md. 4 ☐ Donation 5 ☐ Other (Specify) Am ame teams of cilions Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 eeal M00483 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 0 Yrs Physician CONYRS /Medical Due to s a consequence of): Examiner vertens 100 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed b I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 3 ☐ Probably 4 ☐ Unknown 1 □ Yes Be Completed Secondary 24a. Was an 24b. Were autopsy findings available prior to completion of cause of , page 2 s perform death? 1 ☐ Yes 2 No 1□ Yes 2 No Hospital or Attending Physiclan: funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural n 24 hours after death.

Ne Funeral Director: Af bletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 🖅 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. the

State Registrar

31. Date filed (Month, Day, Year) **JAN 31** 

29b. Signature and title of certifier

nd addres

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30. Name

2008

of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. 4 U U & Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 26 2<sup>Year</sup> 2008 **Physician** Mildred Selby January 6:05 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Heritage Harbour Health & Rehab Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Nov 11 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 1 F Maryland 80 Yrs 194-20-9963 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at Maryland Prince George's Director 1 ☐ Yes 21 No Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 'nent of Health and Mental Hygiene. 1511 Hunter Mill Ave 20744 Funeral USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No þ Specify: Black 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) the 10th 0 Laundry Supervisor Inn Town Totel Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis Edward Coulbourne Sr. Georgie Ophelia Purnell ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20744 Barbara Stevenson(Daughter) Important: If Item 27 any injury or other tra 1511 Hunter Mill Ave Ft. Washington, Md. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity UMC Cem 2-2-08 Unionville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Wanname Practice of Michigans Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 Harr 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** rear. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Year 5 ☐ Other (specify) 4☐Pregnant at time of death detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 22 No certificate I 1☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2**N** No Hospital: 1 🗌 Yes Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending Natural 5 Pending investigation Injury 1 TYes 2 No 2 Accident 24 hours after death e Funeral Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the

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State

Registrar

. Name and address of person who

29b. Signature and title of certifie

fense they, Crofton, mp 21114

mpleted cause of death (Item 23a) (Ty

29d. Date signed (Month, Day, Year)

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FFEMALE: 23b. Was decedent pregnant in the past 12 months?   1   Yes 2   No   1     Yes   2   No   1     Yes   2     No   1     Yes   2     No   1     Yes   2     No   1     Yes   2     No   1     Yes   2     No   1     No   No   No   No   No											
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25. Was case referred to medical examiner?  1   Yes   2   No   Hospital:   I   Inpatient   2   ER/Outpatient   3   DOA   Other:   Was a single of Death (Check only one of	Month Day Year										
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	28f. Location (Street and Number or Rural Route Num City or Town, State)										
29a. Certifier  29a. Certifier  Check only   ause(s) and manner as ate and place, and due	stated. to the cause(s)										
29a. Certifier (Check only one)  29b. Signature and fittle of certifies  29c. License number  29c. License number  29c. License number  29c. License number	9d. Date signed (Month	h, Day, Year)									
D45092	1/30/200	)8									
29b. Signature and office of certifies  29b. Signature and office of certifies  29c. Excepts thinlier  D45092  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  10 Hospital A Sutte 205 Prince Freder  State  Registrar  FEB 0 1 2008 Forms  Apparature  Apparature  PEB 0 1 2008 Forms  Registrar	ende de	20678									
State State Registrar  State  31. Date filed (Month, Day, Year)  FEB 0 1 2008  State											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fh g8/6 2-27-08 vt.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 26, Ada Lorenza Saluzzo 2008 5:30  $P^{M}$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death **Examiner** 1378 Primrose Road Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security (1) 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F 220-56-8844 68 Director Aug. 10, 1939 Argentina Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Maryland Anne Arundel Annapolis 1 No 2 No Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 1378 Primrose Road 21403 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2**XX**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes **XX**No White Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Cleaning 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if item 27 is marked ofth any injury or other traumatic event, one. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Desiderio Gomez Margarita Livio 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruno F. Saluzzo/husband 1378 Primrose Road Annapolis, Maryland 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Mem. Gardens 2/1/2008 | Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home toda 147 Duke of Gloucester St., Annapolis, MD 21401 Approximate Interval Between Onset and Death 1/2 yrs. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Gall bladder cancer **Physician** 1 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner y physician and as the burial-transit that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy 1∐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes XXNo 1 Inpatient 2 ER/Outpatient 3 DOA 70 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? Certification: Hospital or Attending Natural 5 Pending Injury the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29b. Signature and title of co 29c. License number 29d. Date signed (Month, Day, Year) D19838 Jan. 28, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stuart E. Selonick, MD 900 Bestgate Road Annapolis, Maryland 31. Date filed (Month, Day, Year) 32. Segistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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	/Medic Examin	- 3	4a. Facility Name (h	toward (	ve street and number	3		4b. City, 1	Town, or	Location of Death		40	C. County of Dea	ath
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once.	þ		ied 2 Married 4 ☑ Divorced	Armed Forces 1  Yes 2  If Yes, Give Year or Dates:	≬No		1 ☐ Yes 2	2⊠ No	Specify:	o Hican, etc.)		Black, Wh	White
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Ш	<u>207</u>		23a. Part1. Enter t	the disease, or cor	mplications that cause y one cause on each	ed the deat	h. Do not er			1y Ave.	-		MD 2140	Approximate Interval Between
	Physician		Immediate Cause disease or condition	(Final	y one cause on each	line.	Cand							Onset and Death
~	/Medical Examiner		resulting in death)		Due to (or a	as a conteq	uence of):							18 months
		ner	Sequentially list co	onditions, nmediate	b. Due to (or a	s const q	juence of):							
	xecuted and Il-transi	Examiner	Cause (Disease or that initiated events resulting in death)	injury s	cDue to (or a	is a conseq	uence of):							
8760,	cate be e physician the buris	- 1		•	d									
P.O. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 9 □ Unknown	months?	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Feta	al death 3	□Ectopic pr □ Other (sp		у			23d. Date of o	delivery Day Year
	quires that t n signed by uld be deta	b S	Part II. Other signi	ificant conditions	contributing to death	but not res	sulting in the	underlying o	ause giv	en in Part I.				to the cause of death?  Probably 4 Nucleon
Division or Vital Records,	The law recate has bee page 2 short	Completed									24a. W ai p- 1∐ Ye	utopsy erformed?	prior t death	
Vita	ician: certific rector,	Be	25. Was case refe examiner?		Hospital:		Immin		Oth	26. Place of De	1		a-Flour (0	Danahtanila
on or	iding Physith. Th. After this funeral di	tion: To	1 ☐ Yes 2 ☐ 27. Manner of Dea 1 ☐ Natural 2 ☐ Accident	th 5 □ Pending investigati	28a. Date of Ir (Month, E		28b. Time Injury		28c. Inju Wo	4 LI Nursing F			jury occurred	Residence
ivisi	r Atter ter deal irector i by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine	a 20e. Place of I	injury - At h	ome, farm, s fy)	treet, factory	y, office			n (Street Town, Sta		Rural Route Number,
۵	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical Cer	29a. Certifier (Check only one)	ertifying F	Physician: To the beaminer: On the basis and manner	of examina	owledge, dea ation and/or	ath occurred investigation	at the ti	ime, date and plac opinion, death occ	e, and due to urred at the ti	the cause ne, date a	e(s) and manner and place, and c	as stated. due to the cause(s)
	To the within To the comple	Me	29b. Signature and	d title of certifier	- Phu	MD		290	c. Licens	se number 0 64	379		Date signed (Ma)	
	10/0		30. Name and add	Iress of Jers wh	o completed cause of	her	900	Print)	32	Rd Su	te 300	A	neply	MD 2140)
	St Regist		31. Date filed (Mon		2008	strar's Sign	ature	bert	,				Ü	

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Doublest State   First Nation   Line   Congress   Congr			1	For State Registrar	State of Maryland		nt of Health and M te of Death		jiene leg. No: () (	)8 (	14539
Prince of the control										Year	
## 15 Specific Security Number   100 Specific Properties   100 Specifi				Dorothy Sc	Mole				27 (	38	8- Am M
The control of the co				4a. Facility Name (If not institution, give	street and number)	4b. City	Town, or Location of Death	1	4c. County	of Death	
Direction   Dire				HCBNC	7 A (/m	Bu Bu	r 1 Year   If Under 24 Hrs.	8 Date of Birth	7701	9. Birthola	ce (State or Foreign
The State of American State of American State of American State of	П			1	The second secon	Months	7	(Month, Da)	1929	Countr	y) '
Top   December   Program   Top   T			-		10				7,5-1		
Privacion   Priv		yland		10a. State 10b. County	10c. City	, Town or Location	18.1.			10	
Privacion   Priv		Ba-f el	cto		rd E	Micott	City		10a Citizen of	What Count	
Privacion   Priv		ith th	Dire	10e. Street and Number	11 + 0.	10t. Z	2/A//		115	4	,,.
Privacion   Priv		e 23e	era		12. Was Decedent Ever in U.	S. 13. Was Dec	adent of Hispanic Origin? (S	pecify Yes or No-			
The property of the property o			-un		Armed Forces?	If Yes, sp	ecify Cuban, Mexican, Puen	o Rican, etc.)	Dia	1.	ic.
The property of the property o	2	urs af	P P		If Yes, Give Year or Dates:	1 U Yes	2 No Specify:			Dia	ch
The property of the property o	<b>P</b>	72 ho	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give kind of w	ork done during most of wor	rking	16b. Kind of E	Business/Indi	ustry
17. Father's Name (First Middle, Last)   19. Mother's Name (First Middle, Maxim Surrame)   19. Mother's Name (First Middle, Maxim Surrame)   19. Mother's Name (First Middle, Maxim Surrame)   19. Mother's Name (First Middle, Last)   19. Moth	7	hen "	n de			-1	1 1./		School	1 SV.	stem
Record   Specific	7	Hygie Ther t nt, in	ပိ	17. Father's Name (First, Middle, Last)		Laverin		me (First, Middle,	Maiden Suma	me)	
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Record   Specific	<u></u>	shoul nd Ma mari	F	19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mailing Addre	ss (Street and Number or Ri	ural Route Numbe	er. City of Town	n, State, Zip	Code)
Record   Specific	Ž	elth a		Cleveland C. Su	nple (Husband	1221671	4Albert Bd. L	Micott	C+4.1	10 .2	1042
Physician Medical Examiner  Ph		of He of He roth			′ .	Place of Disposition (Nemetery, crematory of	other place)		20c. Location	- City or 10	Wh, State
Physician Medical Examiner  Ph	Ĕ	Peg ment ent: I		4 ☐ Donation 5 ☐ Other (Specify	IVA	Garrison	1 01001	-2008	Dwing.	5 11 11	15./11/
23a. Part 1. Entire the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Physician   Interdical Examiner   Interdical Examin	ă	ermit.		21. Signature of Funeral Service Licens	- les	22. Name	and Address of Facility	Pag	20 g	7 Bri	Leaville Vo
Physician Medical Examiner  Togo as a consequence of the control of the second properties o		20 ≥ • a		one Double Easter the diseases or come	lications that caused the death	h Do not enter the m	ode of dving, such as cardia	c or respiratory a	rrest,		Approximate
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Due to (or as a consequence of):    Constitution				disease or condition	d.		ne Liver				
The past 12 modes of the past					- 101	1	er Disease				
The completion of cause of death of the standard of the stan			Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):					
The completion of cause of death of the standard of the stan		cuted nd ransil	aml	that initiated events	c	-0.					
The part of the pa	Ď,	e exe		resulting in death) Last	Due to (or as a conseq	uence or):					
So the second program of the past 12 months		cate b			d						
25. Was case referred to medical examiner?  1		ding (	/Me						23d. E	Date of delive	
25. Was case referred to medical examiner?  1	å	atten after u	clar	in the past 12 months?	4 Pregnant at time of d				, A	Month	Day Year
25. Was case referred to medical examiner?  1	o.	the d	hys	9 🗆 Unknown					- 1		- sauce of death?
25. Was case referred to medical examiner?  1		s thei	oy P	1 1		sulting in the underlyin	g cause given in Part I.			~	
25. Was case referred to medical examiner?  1	ğ	equire en sig ould b	led 1	Esophageal Va	wes						
25. Was case referred to medical examiner?  1	မင္ပ	lew ras be	ple	Hypertension				auto	DDSV	prior to co death?	mpletion of cause of
29a. Certifier  29a. Certifier  29a. Certifier  Check only  Check	<u>=</u>	: The cate h	Con	1 ,				1 Tes	2 2 No	1 🗆 Yes	2□ No
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29a. Certifier  29a. Certifier  29a. Certifier  Check only  Check	o	Phys r this ral din		h ————————————————————————————————————	28a. Date of Injury	28b. Time of		-			,
29a. Certifier  29a. Certifier  29a. Certifier  Check only  Check	0	ding th. Afte	ig	in							
29a. Certifier  29a. Certifier  29a. Certifier  Check only  Check	Visi	Atter or dea octor by the	He	3 ☐ Suicide 6 ☐ Could not b	: 288. Flace of filluly - At I	nome, farm, street, fac	tory, office			mber or Rur	al Route Number,
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29c. License number  29d. Date signed (Month, Day, Year)	ō	ital or rs afte el Dir	Cert						= nouse(s) == 1	managarar	tated
29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Separature		Hoepi 4 hou Funer ely fill	cal	(Check only 2   Medical Exar	niner: On the basis of examin	ation and/or investigat	tion, in my opinion, death oc	curred at the time	, date and plac	e, and due t	o the cause(s)
30. Name and address of person who completed cause of death (item 23a) (Type, Print)  Dorothy Scay 25 Main Street Reisterstown MD 21208  State  31. Date filed (Month: Bay, Year) 2008  32 Segistrar's Signature		thin 2 the othe	Med		and manner stated.		29c. License number		29d. Date sig		
30. Name and address of person who completed cause of death (item 23a) (Type, Print)  Dorothy Secry 25 Main Street Reisterstown MD 21208  State 31. Date filed (Manufacture) 2008 326 degistrar's Signature		7 × 7 8			1×6		DOUS333	7	Jane	cen 2	8,2008
State 31. Date filed (Month Pay, Year) 2008 32 Against Signature	•	Sul		30. Name and address of person who	completed cause of death (ite	m 23a) (Type, Print)				- 1	
State 31. Date filed (Month: Bay. Year) 2008 32 degistrar's Signature		5 110		Dorothy Seav	25 Main S	freet Rei	sterstown M	D 212	08		
				31. Date filed (Menth: Bay, Year) 20	32 Registrar's Sign	lature Asset					

08-01096 William Trzaska Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

liam Trzaska	а	1-	State of Mai	yland / Departi <i>Certif</i>	ment of icate of	Death	i Wentan		g. No.	200	8 0454
Physic	ian/		listrar Decedent's Name (First, Middle,Last)					2. Date of Deat	h Day V	ear	3. Time of Death 1230 hrs
dical Exam	ine		William John Trzasl	ca		b. City, Town, or	Leastion of Des	February	7, 2008	y of Death	12301113
		48	Facility Name (if not institution, give street ar 12827 Kitchen House Way	d number)	4	Germantow		201	Montg	•	
Euroro		5.	Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year			th (MM/DD/YY	YY) 9. Birti Foreig	nplace (State or
Funera Directo			13-32-7530   1X M 2	<sub>F</sub> 65	Yrs.	Months Days	Hours M	Sept.	23, 19	42 Cou	nuntry) NY
		-	ual Residence of Decedent	10e City To	own or Locati	on.					10d. Inside City Limits
w any		1	a. State 10b. County  MD Montgomery	Toc. City, To		ntown					1 Yes 2 X No
yland yland a-f sho	ţ	-	e. Street and Number			10f. Zip Code			0g. Citizen of		
death with the Maryland or items 23a or 28a-f show	Director		12827 Kitchen House	Way			20874		United		
with t ms 23s	2		. Marital States	s Decedent Ever in U.S. ed Forces?	13. Wa	s Decedent of His es, specify Cubar	spanic Origin? ( n, Mexican, Pue	(Specify Yes or No erto Rican, etc.)		ace - Ameri hite, etc.	can Indian, Black,
r death or ite	Fineral		Never Married 2 Married 1	res 2 X No	1	Yes 2 X No	specify:		Specia	fy: T	√hite
irs afte ural",	2	7)-	Widowed 4 X Divorced If Yes, Gi or Dates:  15. Decedent's Education (Specify only highes)	t grade completed) 1	6a. Deceden	nt's Usual Occupa	tion (Give kind	of work done	16b. Kind of	Business/	Industry
72 hou n "uat	ompleted			ege (1-4 or 5+)	-			remooy	Quan	rv	
0036 within iene.			10 7. Father's Name (First, Middle, Last)		Loa	ader Ope	rator 18.Mother's Na	ame (First, Middle,	1 '		
21215-0036 und be filed within 72 hours after Mental Hygiene. marked other than "natural", connect the Modical Evantiner	Ent., tille	ין י	Walter Trzaska				Rose	mary Ham	i11		
MD 21215-0036 2 should be filed within 72 hours after h and Mental Hygiene. 2 73 is marked other than "inatural"; or standard other Modifical Fyaminer.	E C		a. Informant's Name/Relationship (Type, Prin		Į.			or Rural Route Nu			
MD Id 2 sho Ilth and m 27 is	E C		Pamela Trzaska / Sis Da. Method of Disposition	2.21	( 5)	. 'a' (Name of or	House emetery,	Way, Ger	20c. Locati	on - City or	Town, State
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Mc Important: If item 27 is ma	ner d		Oa. Method of Disposition  Burial 2 Cremation 3 Rem  Donation 5 Other Specify:	oval from State Metr	ematory or of	ther place) tan		ebruary 11, 2008	Δ1ex:	andri	a, <u>Virginia</u>
Itim it Pag rtment	y or 0	L	Donation 5 Other Specify:  1. Signature of Funeral Service Licensee		22.1	Name and Addres	s of Facility D	eVol Fun	eral Ho	ome,	10 East
Ba perm Depa Imp	mfu	1	TOACHARALES					Gaither			Approximate Interval
Physicia		1	3a. Part I. Enter the disease, or complications failure. List only one cause on each line.				, such as cardi	ac or respiratory a	nest, snock, o	Tiodit.	Between Onset and Death
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	ı	-	b. b.							_	
			any, leading to immediate Due to ( ause. Enter Underlying Cause	or as a consequence of)	i.						
h -	=	Εļ	Discourse as informs that initiated	or as a consequence of)	ı						
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30, te be e: tysiciai	- burial -	ledical	Y UNPENDED AME #2 F FEMALE: 23c.	IDED 3a PTT 27 De If yes, outcome of pregn	erME.g87 Jancy	77. 3/3/08	777			te of delive	•
5876 ertifica ding ph	as the	an/a	Bb. Was decedent pregnant in the past 12 months?	Live birth Pregnant at time of dea	2 F	Fetal death 3 Other (Specify)	Ectopic pr	regnancy	Mor	ith	Day Year
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ords, P.C v requires that s been signed l	<u>ع</u> ا	Completed by	Hypertensive atheroscl	<u>ertic cardiova</u>	ascular	disease:	<u>liver cir</u>	Thosis 24a. Wa		24b. Were	autopsy findings available
Vital Records, ysician: The law requir this certificate has been s	shoul 2	Bet						pe	topsy rformed?	death?	
Rec The la	page	န္ပြ				26 Pla	ace of Death (Cl	1 Ye	s 2 No	1 🗸	Yes 2 No
ital ician: s certif	rector	8	25. Was case referred to medical examiner?	1 Inpatient 2	ER/Outpatie			Nursing Home 5	Residence	6 🗸 Ott	ner: Scene
of Vil ing Physic After this	rai	빍	1 ✓ Yes 2 No 27. Manner of Death 28	a. Date of Injury (Month, Day,Year)	28b. Time o		njury at Work?		oe how injury o	ccurred	
ion ( tendin eath.	the fur	흲	1 A Natural 5 Pending				Yes 2 N		n (Street and I	Number or	Rural Route Number, City
ivis or At after d	d in by	Certification:	3 Suicide 6 Could not be	se. Place of Injury - At ho Specify)	ome, farm, st	reet, factory, offic	e building, etc.		n, State)		
Ospital hours			4 Homicide		ge, death occ	curred at the time	, date and place	e, and due to the c	ause(s) and m	anner as s	tated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis.	nplete	Medical	one) 2 Medical Examiner: On the	e basis of examination a anner stated.	nd/or investi	gation, in my opin	ion, death occu	rred at the time, d	ate and place,	una coo to	
3	8	Ř	29b. Signature and title of certifier	1			ense number C.M.E.		- 1	e signed (/ ary 8, 20	Month, Day,Year) 08
5			Calmin	12	4		∪.IVI.E. 			, 0, 20	a comparation and
			30. Name and address of person who completed Zabiullah Ali, M.D. Assistant	ted caus of death (Item Medical Examiner	123a) 111 Po	enn Street, B	altimore, Ml	D 21201			
	St	ate	31. Date filed (Morth Bay, Year) 2008	32. Registrar's Signatu		actes					
Re	gist		LED T % 7000	District &	197	and the second					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Clayton Thibeault Alfred 31, 2:30 p<sup>M</sup> January 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2512 Gittings Court Charles Waldorf 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 1X) M 2□ F Months Days Hours 049-38-9215 60 June 4, 1947 Maine Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 3/☐ No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2512 Gittings Court 20602 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □XYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1967-Specify: White 1 ☐ Yes 2√2 No Specify 3 ☐ Widowed 4 ☐ Divorced 1971 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Mail Carrier U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest Thibeault **Yvette** Poulin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carie Myers Daughter P.O. Box 386, Welcome, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 2, 200 Metropolitan Funeral Service 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licen 22. Name and Address of Facility Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. pase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line.

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

by

Completed

Be

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**Funeral** 

Director

d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

marked other

Department of Health and Mental I Important: If Item 27 is marked of any injury or other traumatic evenoce.

72 hours after

Pages 1 and 2 should be

Baltimore, Maryland 21215-0036

burial-tra signed to

law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

disease or condition resulting in death)	Due to (or as a conse		eart di	seese	
Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	b				
cause (Disease of Injury that initiated events resulting in death) Last	C	quence of):			
Sequential list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome pf pregr 1 □Live birth 2 □ Fer 4 □ Pregnant at time of 9 □ Unknown	tal death 3 □Ectopic	c pregnancy (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not re	sulting in the underlyin	g cause given in Part I.	23e. Did tobacco u	use contribute to the cause of death?
				24a. Was an autopsy performed? 1  Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 ► No
25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)	
1 Ses 2 No	Hospital: 1 Inpatient 2	]ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5. Residence	6 ☐Other (Specify)
		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	ry occurred
3 Suicide 6 Could not 4 Homicide determine		nome, farm, street, fact	ory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number, e)
27. Manner of Death  1 Natural 2 \ Accident 3 \ Suicide 4 \ Homicide  29a. Certifier (Check only one)  29h. Signature and title of certifier	Physician: To the best of my kn aminer: On the basis of examin and manner stated.	owledge, death occurr ation and/or investigat	ed at the time, date and place ion, in my opinion, death occ	ce, and due to the cause(s)	) and manner as stated. d place, and due to the cause(s)
29b. Signature and title of certifier			29c. License number	29d Dat	te signed (Month, Day, Year)

29c. License number

00050883

MD

Hospital or Attending 124 hours after death.

Pe Funeral Director: A pletely filled in by the fu

31. Date filed (Month, Day, Year)

FEB 0 4 2008

(a

212108

70646

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11655 WINESOD

Tagouri

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mont Year **Physician** 2008 urner  $\alpha \cap \alpha$ /Medical Facility Name (If not institution, give street and number 4c. County of Death Examiner If Unde 5. Social Security Number Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Hours Months Davs 1 ☐ M 2 💢 F 34 8/7/1973 Washington, DC Director 215-76-7129 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 Tyes 2 No Director Maryland Anne Arundel Harwood the 10e Street and Number 10f Zip Code 10g, Citizen of What Country? death with 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r 4841 South Polling House Rd. 20776 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or iter 1 Tes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 vears Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eugene Joseph Stefko Mary Ann Prezioso ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adam R. Turner/ Husband item 27 i 4841 South Polling House Rd., Harwood, MD 20776 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/2/08 4 ☐ Donation 5 ☐ Other (Specify) Our Lady of Sorrows West River, MD 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hoda disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner Sequentially list conditions Due to or as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as IF FEMALE use a 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for 1 in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. ed by the a detached f 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 1∐ Yes 2 N 25. Was case referred to medical examiner? rector, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2) No 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ۵ After this funeral dir Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation (Month, Day Year) 1 Natural Injury s after dec. 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide ō To the Hospital within 24 hours of To the Funeral D 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

State Registrar 31. Date filed (Month,

DHMH 17 Rev 1/2001

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Relistrar's Signature

Year)

3 1 2008

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death

1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death 31, 2008 **Physician** WILLIAM PAUL THOMAS JANUARY 9:25 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL CENTER CLINTON PRINCE GEORGES 8. Date of Birth (Month, Day, JUNE 26, 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 → M 2 □ F 1955 MARYLAND 52 220-62-8723 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 TYes 2 □ No Directo MARYLAND CHARLES WALDORF 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES 11741 ACTON LANE 20601 Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify. þ 3 Widowed 4 Divorced BLACK "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
12TH GRADE College (1-4or 5+) BUILDER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HILLERY JOSEPH THOMAS, SR. ELNORA MARIE JUPITER THOMAS CHASE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11741 ACTON LANE, WALDORF, MARYLAND CINDY THOMAS / SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SHILOH CHURCH CEM. FEB. 4,2008 NEWBURG, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Acenses THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 THORNTON LADIA C. JOHNSON MO0583 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ru **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Lus to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending physic for use as the b IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1∐ Yes 2 ₹No To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA မှ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 ANatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

within 24 hours a

State Registrar

Medical

29a, Certifier

(Check only

29b. Signature and title of certifier

Nalin Mathur, MD 11855 Holly Lane Suite 107 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Radistrar's Signature

🛮 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D52289

Waldorf, Maryland

29d. Date signed (Month. Dav. Year)

2000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month Day Doris Townsend 2008 0200 Feb /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death Satisburg Rehaba Nursing
5. Social Security Number | 6. Sex | 7. Age //nw Salisburu Wicomica if Under 1 Year | If Under 24 Hrs. 7. Age (Inyus, last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🛛 F 83 Director 219-14-4185 6/18/1924 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits show "natural", or items 23a or 28a-f shovedical Examiner must be notified at Director 1 X Yes 2 □ No Wicomico Maryland Salisbury 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1514 Riverside Dr., Apt. Bl14 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 □ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. þ Specify: white 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Med Elementary/Secondary (0-12) College (1-4or 5+) 8 seamstress shirt\_manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles M. White Nalia Wells ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Bonnie Smith/daughter 31135 Ward Rd., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Wicomico Memorial 4 ☐ Donation 5 ☐ Other (Specify) 2/4/08 Salisbury, MD Park 21. Signature of Funeral Service Licensee 2. Name and Address of Facility
Holloway Funeral Home Professional Association Media Contraction of the Contrac 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** mes /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 4 ears Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown vate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes the Hospital or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Matural Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide 1 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2.

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760.

State Registrar

29b. Signature and title of confifier

illiam

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Robins, M

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32. Registrar's Signature

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FEB 04

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29c. License number

29d. Date signed (Month, Day, Year)

ivic Ave, Salisbury, MD 21804

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nthony J. Vallie		State of Maryland	/ Departme				Menta	i Hyg		eg. No. 2 [	108	01.51	
Physici	an/	Registrar  1. Decedent's Name (First, Middle,Last)					·		Date of Dea	th		e of Death	
ledical Exami	ner	ANTHONY J. VA  4a. Facility Name (if not institution, give street and numbe	LLIERE	14	b. City, Tov	wn. or Lo	cation of I		Month January 2	6, 2008 4c. County of		35 hrs	
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Funeral		5. Social Security Number 6. Sex 7. A	6. Sex 7. Age (In yrs. last birthd			1 Year Days	If Under 2	24Hrs. Min.	8. Date of Bu	th(MM/DD/YYYY)	9. Birthplace Foreign	(State or	
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any		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	r Locatio	on						10d. Ir	nside City Limits	
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i, MD and 2 sho ealth and tem 27 is		CLAUDE VALLIERE/FATHE  20a. Method of Disposition	R. 7						., PAL	ATINE, I			
DOFE ages 1 nt of H t: If ii		1 X Burial 2 Cremation 3 Removal from S	nate [	•	er place)	T73.437	OED.	o -	, 2000	ANNADOI	TC MI		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other Specify: 21. Signature of Funeral S ice Licensee	JU.S. NA							ANNAPOL			
<b>m</b> F P F iii		WM Chamburge	M00091	58	301 C	LEVE	LAND	AVE	,MRIV	CREMATOR ERDALE,	MD. 20	737	
Physician /Medical		23a. Part I. Enter the disease, or complications that cause failure. List only one cause on each line.		enter th	e mode of	dying, su	ich as card	diac or re	espiratory ar	est, shock, or hea		roximate Interval ween Onset and	
kaminer		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injurie  Due to (or as a con									_	Death	
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be be			ome of pregnancy							23d. Date of d	delivery		
687 ertifica ding p	sician/M	23b. Was decedent pregnant in the past 12 months?	2	_	al death	3	Ectopic p	regnand	У	Month	Day	Year	
Division of Vital Records, P.O. Box 68760 to the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the br	ysic	1 Yes 2 No 9 Unknown g Unknown	at time of death 5	Oth	er (Specif	y)				2			
P.O. Es that the d	y Phy	Part II. Other significant conditions contributing to dea	ath but not resulting	in the u	nderlying c	ause giv	en in Part	l.		obacco use contrib	_		
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Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sided in by the funeral director, page 2 should be	Completed								24a. Was auto	psy pr		findings available tion of cause of	
Ital Rec ician: The l scertificate b	S								1 🗸 Yes		✓ Yes	2 No	
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of VII ling Physic After this funeral dir	5	27. Manner of Death 28a. Date of Ir	jury 28b. Ti	ime of Ir	Service of the Control of the Contro		at Work?	2	8d. Describe	how injury occurre	ed	-	
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ivis lor At after d Direc	Certification:	3 Suicide 6 Could not be 28e. Place of	Injury - At home, far		t, factory, o	office bui	lding, etc.		or Town,	Street and Numbe			
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Divisior  To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	293. Certifler 1 Certifying Physician: To the best of one)  2 Medical Examiner: On the basis of example 2	amination and/or inv									e(s)	
T w i o	Me	29b. Signature and title of certifier	ı	-	29c.	Lìcense i	number			29d. Date signe	d (Month, Da	ıy, Year)	
941		some Hex N	0			O.C.M	.E.			January 27	2008		
• ``		30. Name and address of person who completed cause of		1111	Penn Sti	root P	altimora	2 VAID :	21201				
-60	ate	Tasha Greenberg MD. Assistant Media  31. Date filed (Month, Day Year)  33. Regist	rar's Signature	1111	eiii Sti		aiumore	5, IVID .	£ 1 £ U I				
Regis		FFB 0 1 2008	a St A	A STATE OF THE PARTY OF THE PAR									

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** January 8:05 pm<sup>M</sup> Rubye\_Elizabeth\_Valentine 30, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Misty Ridge at Bloom Valley Carroll Westminster 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours 1 M 2 3 F Yrs. Director Aug 09 1914 Miss 93 579-28**-**9053 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Westminster MD Carroll Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21157 3830 Baker Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No \$ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Safeway Stores 12 Head Bookkeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be item 27 is marked r other traumatic e Mattie Logan William Lawrence Price 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1810 Benedict Road Westminster, MD Sylvia Haines/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 02/03/2008 permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Immanuel Lutheran Church Cem Manchester, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pritts Funeral Home & Chapel, P.A. 21. Signature of Funeral Service Licenses 412 Washington Rd. Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocend /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 mg Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 donknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perforn 2 No 1∏ Yes Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes, 2 thNo Hospital: 1 ☐ Inpatient Other: 4 Sursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral D

completely filled in 29a. Certifier 1🗹 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ۵ 131/08 52 000 50763

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State Registrar

FEB 0 1 2008 Steam St. Spark

32. Registrar's Signature

30. Name and address of person who completed cause of peath (Item 23a) (Type, Print)

MD

Ernesto Mendoza,

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

826 Washington Road

Suite #120

Westminster, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 9:30 Robert Eugene Werner January 29, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mont. Village Care & Rehabilitation Montgomery Village Montgomery If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Jan 16, 1920 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Pennsylvania 88 161-16-4047 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Derwood Director Maryland Montgomery 10a. Citizen of What Country? 10e. Street and Number 10f, Zip Code ö 20855 United States 7616 Warbler Lane "natural", or items 23a permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner musts Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Tayes 2 No World
If Yes, Give
Year or Dates: War II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) U. S. Customs Elementary/Secondary (0-12) College (1-4or 5+) 12 Deputy Inspector Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Toth Stewart Werner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7616 Warbler Lane, Derwood, Maryland 20855 Rose Mary Werner (Wife) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Metropolitan February 1, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify 2008 Crematory Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service License 23a. Parti. Ehlerithe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, or heard failure. List only one cause on each line.

Immediate Dause (Final disease or condition resulting in death)

a. Coronary Artery Disease 10 E. Deer Park Drive, Gaithersburg, MD 20877 Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-tran and Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) signed by the at d be detached for IT Ves 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. 9 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Dementia Completed 24a. Was an autopsy performed?
1□ Yes 2 🗓 No 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 1 Tyes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) To the Hospital or Attending within 24 hours after death. 5 Pending investigation 1 💢 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ca

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(Check only one)

29b. Signature and title of cartifier

31. Date filed (Month, Day, Year)

FEB 0 1 2008

Anushiravan Dadgar, M.D., 9715 Medical Center Drive, #201, Rockville, MD 20850

29c. License number

HO0 51280

29d. Date signed (Month, Day, Year)

1-19-2008

and manner stated.

*⋒*egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State	Please		aryland / De	I <b>ndelible Ink</b> partment of I <i>ertificate of</i>	Health and N	-	Are Legible.	
.661-	Physic		1. Decedent's Name (First GENG WAN		ast)		erinicale or	Death	2. Date of Dea Month January	Day Year	3. Time of Death 1:00 P
	/Medi Exami		4a. Facility Name (If not in Casey House		ve street and number)		4b. City, Town, Rockvi	or Location of Death .11e		4c. County of Dea Montgome	th
	Funeral Director		5. Social Security Number 444–98–7067		Sex 7. Ag 1 → M 2 □ F	e (In yrs. last birthd 49 Yrs	Months Days		8. Date of Birt (Month, Day Dec 1	<sup>h</sup> Year) 9. Bir 5, 1958 Ch	thplace (State or Foreig Juntry) ina
	h the Maryland r 28a-f show r notified at	ctor		ent County ontgor	nery	10c. City, Town or North I					10d. Inside City Limits
	death with the ns 23a or 28 must be not	Funeral Director	10e. Street and Number 13825 Ranch	Plac	ee	<del></del>	10f. Zip Code	0878		10g. Citizen of What Co United Sta	,
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 3 □ Widowed 4 💆 Di		12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	Ever in U.S. 1	3. Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 [X] No		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: As	e, etc.
21215-0036	within 72 ho iene. • than "natur the Medical I	Completed	15. Di (Specify only Elementary/Secondary (		ducation ade completed)  College (1-4or 5	(G life	cedent's Usual Occu ive kind of work done e. DO NOT use retire Computer	during most of worked)	ing	16b. Kind of Business	
Maryland	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Me	To Be C	17. Father's Name (First, I Yaokang Wa		t)			18. Mother's Name		Maiden Surname)	
	1 and 2 sh Health and tem 27 is m		19a. Informant's Name/Re Weiping Lu			1227	5 Greenle			er, City or Town, State, A	Zip Code)
Baltimore,	permit. Pages 1 Department of H Important: If itel any injury or ott		20a. Method of Disposition 1 ☐ Burial 2 【XCren 4 ☐ Donation 5 ☐ C			cemetery, o	sposition (Name of crematory or other pla litan Crem	тев.	Date 2	20c. Location - City or Alexandria	
Balt	permit. Depart Import any in		21. Signature of Funeral S	ervice Lie	DUA		22. Name and Addr 10 East D	De		eral Home thersburg,	MD 20877
	Physician /Medical Examiner		23a. Part1. Enter the dise shock, or heart failur Immediate Cause (Final disease or condition resulting in death)	ase, or cor e. List only	a. Renal	the death. Do not ne.  Cancer a consequence of):	enter the mode of dy	ing, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
,09	be executed ician and burial-transit	al Examiner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last	e $\left\{ \right.$	c	a consequence of):					
P.O. Box 687	death certificate e attending phy: d for use as the	by Physician/Medic	IF FEMALE: 23b. Was decedent pregn in the past 12 month: 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	су		23d. Date of del Month	ivery Day Year
	quires that n signed build be deta	d by Pl	Part II. Other significant of	onditions	contributing to death bu	ut not resulting in the	e underlying cause gi	ven in Part I.		obacco use contribute to ′es 2 □ No 3 □ Pt	
al Records,	The far ate has page 2	Completed							24a. Was a autop perfor 1∐ Yes	sy prior to	utopsy findings available completion of cause of 2  No
or Vital	<u>a</u> + <u>r</u> g	: To Be	25. Was case referred to rexaminer? 1 ☐ Yes 2 ☐XNo 27. Manner of Death	nedical	Hospital: 1 Inpatie		ICIT OLI DOX		me 5 Resid	ence 6 AOther (Spe ow injury occurred	<sub>cify)</sub> Hospice
Division	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director; After th completely filled in by the funeral	Certification:	1 X Natural 5 ☐ 2 ☐ Accident	Pending nvestigatio Could not b determined	(Month, Day	/ Year)   Injur	y Wo	Yes 2 □ No		treet and Number or Ru	ural Route Number,
	e Hospita 124 hours e Funeral letely filled	Medical C	29a. Certifier 1 XC (Check only one) 2 M	ertifying P edical Exa	hysician: To the best of miner: On the basis of and manner sta	examination and/or	eath occurred at the t investigation, in my	ime, date and place, opinion, death occur	and due to the ored at the time,	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
	Valhir Somp	Me	29b. Signature and title of	e W	m Que	Sk m)	29c, Licens	se number 064615	4	29d. Date signed (Mont January 3	
	1		30. Name and address of por. Genevie	ve Wr				Dr. Suite	e 100, R	lockville, l	MD 20850
	Sta Registi		31. Date filed (Month, Day,		44	ar's Signature	parte				

State Registrar MAHESH

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHANDRA

FEB 0 1 2008

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 31, 2008 **Physician** HAZEL DARE WARD 11:15 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 9. Birthplace (State or Foreign Country) Virginia Age (In yrs. last birthday) Year) Days 1 ☐ M 2 🕱 F 316-26-1864 Director 19, 79 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notitled at any or other traumatic event, the Medical Examiner must be notitled at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director Maryland | Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2502 Catoctin Court - 1A 21702 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐**X**No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Jesse J. Morris Shifflett Nettie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Forrest Ward - Husband 2502 Catoctin Court - 1A, Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any Injury or once. Monocacy Cemetery Feb. 5, 2008 Beallsville, Maryland 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home 21. Signature of Fu Frest Damascus, Maryland 26401 Ridge Road, 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or it jury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed inding physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical signed by the attending a IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions)contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 1700 24a. Was an 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 10 Hospital: Inpatient 1 TYes Certification: To 2 ER/Outpatient 3 DOA After this Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certif

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this

> State Registrar

31. Date filed (Month, Day, Year) FEB 04

Robert L. Kaufmann M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

300 West 9th Street, Frederick, Maryland

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** PM Martha Н. Williams 29, January 2:20 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Wicomico 1126 Resden Run If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Yea 2/4/1951 Months Days 1 □ M 2 🕱 F Yrs. 56 Washington, DC 220-52-8933 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "naturai", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Wicomico Salisbury Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21804 USA 1126 Resden Run Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: ģ 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 education teacher permit. Pages 1 and 2 should be filed a Department of Heath and Mental Hygiis Important: if item 27 is marked other any injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lloyd Thomas Hosier Emily Jean Morris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1126 Resden Run, Salisbury, MD 21804 Robert L. Williams Jr/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury Crematory Salisbury, MD 1/31/08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Policy and Address of Facility Home Professional Association Kerl 501 Snow Hill Rd., Salisbury, MD 21804 nenez 23a. Part1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 84rs. 3mos Va /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 TYes 2 No 3 Probably 4 Mount Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy perform 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Deal 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical one and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatur and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 302, Easton, MD Teal Dr., David Smith 8221 egistrar's Signature 31. Date filed (Month, Day, Year) 2008 FEB 01 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Shirley Mae Stanford West 01 25 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SALIS HOSPICE WICOMICO OASTAL THE LAKE Birthplace (State or Foreign Country)
 MD 8. Date of Birth (Month, Day, Year) Jan 24, 1936 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 ☐ F 72 220-32-2331 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show 1√2Yes 2□No MD Wicomico Delmar ortant: If item 27 is marked other than "natural", or items 23a or 28a-f st Injury or other traumatic event, the Medical Examiner must be notified 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 1208 Chestnut St. 21875 Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 █**\**No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Black 3altimore, Maryland 21215-0036 Specify 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Public Education Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Granville Jones Mary F. Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1603 Mt. Hermon Rd., Salisbury, MD 21804 Marla Morris/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Springhill Memory
Gardens 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 1/30/2008 Salisbury, MD 21. Signature of Funeral Service Dicense 22. Name and Address of Facility Lewis N. Watson Funeral Home 21801 1618 West Rd., Salisbury, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MRTASTATIC BNDOWRTRIAL CARCINOWA Physician /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of) attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 Yes 2 ANd 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1/ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Phospital or Attending Pi 24 hours after death. Funeral Director: After the 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WARK

29c. License number

29d. Date signed (Month, Day, Year)

HOSPICE PUBOX 1733 SHI'S BUNYUND 21802

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** bruary 13,2008 4c. County of Death ae /Medica 4b. City, Town, or Location of Death Facility Name (# not institution, give Examiner **Funeral** Min 1 MM 2 □ F Director 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County 1 X Yes 2 □ No ns 23a or 28a-f sh must be notified Completed by Funeral Director itimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health and Mental Hygiene. 14. Race - American Indian . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items 2 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 ō Specify: 3 Widowed 4 Divorced lac "natural", 16b. Kind of Business/Industry other than "natur 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation Give kind of work done during most of working life. PO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 7 is marked of traumatic evi ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (W) fe) Monsville 27 S. Shirl Important: If Item 2 any Injury or other 20c. Location - City or Town, State 20b. Place of Disposition cemetery, crematory 20a. Method of Disposition 1 Burial 2 □Cremation 3 □F 4 □Donation 5 □ Other (Specify) 3 □Removal from State 22. Name and Address of Facility JOSEPH L. RUSS 2222 W. North 21. Signal ure of Funeral Service License L. Russ Funeral W. North Ave. Ba 216 ase, or complicate as that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. 23a. Part I. Inter the dis as shock or heart fall re. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a Examine To the Hospital or AttendIng PhysIclan: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) 2 🗆 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 : 2□No certificate 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No 2 ER/Outpatient 3□ DOA Certification: To 1 Tes 1 Inpatient 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a Date of Injury After t (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 No within 24 hours after deam.

To the Funeral Director: / 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 | Homicide 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation is my original data. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check onl) one) 29d. Date signed (Month, Day, Year) 29c. License number e of certifi 29b. Signaty 108 30. Name and address of person who completed cause of

State

Registrar

FEB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Amend #8, perFh, g877 3/7/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year **Physician** 11:28 AM ROBERT LEE AVERETT FERRUARY 11,2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltinoke HARBOR HOSPITAL 8. Date of Birth 8/22/1930. Birthplace (State or Foreign (Month, Day, real) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Country) Months Days Hours Min 1 🕅 M 2 🗆 F Yrs. Director irainia Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State r 28a-f show notified at show 1 Myes 2 No **Funeral Director** MORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or 7 212 14. Race - American Indian. r than "natural", or items the Medical Examiner mu 2. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 MYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 2 3 Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) d 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be marked 9 traumatic and I 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (FT (end) Department of Health a important: If item 27 is any Injury or other tra shorte 20b. Place of Disposition (Name of cemetery, crematory or other place) Town, State 20c. Location - City or 20a. Method of Disposition Pages 1 Bunal 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 Removal from State 22. Name and Address of Facility
Joseph L. Rus
2222 W. North 21. Signature of Funeral Service Licensee Home, P.A. unera 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASYSTOLE DAY **Physician** /Medical Due to (or as a consequence of) Examiner WEEK ACUTE MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner YEAR be executed METASTATIC LUNG CARCINOM burial-tran Due to (or as a consequence of) or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No ed by the a detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 2 No PNEUMONIA 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe this certificate 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 2 No 1 Inpatient 3□ DOA ٩ 1 Tyes 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completely filled in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death. 27. Manner of Death Certification: Natural Attending Division (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or A within 24 hours after To the Funeral Direct 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifiei Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tille of certifier RE 5001 FEBRUARY 11, 2008 m.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 S. HANOVER STREET BALTIMORE, MD DAVID PRESS 31. Date filed (Month, Day, Year) 32, Registrar's Signature State FEB 1 9 2008 Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Bea No.

			For State Registrar		State	of Mary	yland /		rtment <i>ificate</i>				lental Hy	gien Reg. N	6 U	8 0	0455	5
	U.S.		Decedent's Name	e (First, Middle,	Last)								2. Date of D	eath		V	3. Time of Death	
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	Examin	er	4a. Facility Name (I				1 0		4b. City, T					4	c. County o Anne		mđo]	
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	n 282 n 282	Director	10e. Street and Nu	mber					10f. Zip (	Code				10g. C	itizen of W	hat Cour	ntry?	
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H2	filed within 72 hours after death with the Marylar Hyglene. ther than "natural", or Items 23a or 28a-f show ther, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Marr 3 □ Widowed		ed 1 23 Your if Yes	Decedent Event Forces?  Jes 2 No Give Jes Dates:	er in U.S.		as Decede Yes, speci □ Yes 2		ispanic O an, Mexica Specify		ecify Yes or N Rican, etc.)	0-		, White,		
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7 2	ygien ygien ier th	Sol						ınsu	rance	Age		- de Nome	e (First, Middle	1			<u> </u>	
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HANK Baltimore,	permit. Pages 1 and 2 should be Department of Heelth and Menta Important: If Item 27 is marked any Injury or other traumatic es once.		21. Signature of Fu	5 □ Other (Sp uneral Service I		, 0	поту	22.	Name and	d Addre	ss of Faci	ility Hu	bbard 1	Fune	ral H	iome,	Inc.	
	207 2 2		Jul	· aul	Cor	my	_								re, M	aryl	and 21229	<del>)</del>
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	/Medical		disease or condition resulting in death)	))  }	a. Due	to (or as a c	onsequenc	e of):	<b>~</b>	100	4,00	· · /					14 10 1/V4/12	
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ō	ding Physin. h. After this continued fine	: To	1 ☐ Yes 20 27, Manner of Dea			npatient ate of Injury	28b	Outpatient o. Time of		8c. Injur Wor	4 🗀 1		me 5 ☐ Res 28d. Describe				(y)	
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Jivisi	I or Attending after death. Director: After I in by the funer	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could r determ	ot be 28e. P	lace of injury uilding, etc. (	- At home, (Specify)	farm, stre	et, factory	, office			28f. Location City or T			er or Rur	al Route Number,	
_	To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier (Check only one)	1 Certifyin 2 Medicai	g Physician: To Examiner: On the	the best of r	xamination	lge, death and/or inv	occurred estigation	at the ti	me, date opinion, d	and place, leath occur	and due to th	e cause e, date a	e(s) and ma and place, a	nner as	stated. to the cause(s)	
	To the within 2 To the Complex	Med	29b. Signature and	d title of certifier		namer state	u.		290	. Licens	e numbe	r		29d. [	Date signed	(Month	Day, Year)	
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	nul		80. Name and add	TUNA_	who completed		th (Item 23a	a) (Type F	Print).	1.	- 1			M	man	7	, , , , ,	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 1 per doc 8876 2-26-08 vt.
State of Maryland / Department of Health and Mental Hygiene 2 0 0 8

Certificate of Death

Direct 10e. Street and Number 10f. Zip Code 502 Kerby Hill Road 20744 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 □ Yes 2 □ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ X X Yo If ♥es, Give Year or Dates: Vietnam Specify þ Specify: 3√ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **MSGT** 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Truesella James Asberry ဥ 19a. Informant's Name/Relationship (Type. Print) Mirinda Jackson (POA) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Feb 26, 2008 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery 21. Signature of Funeral Service Deparament of the policy of th 23a. P.11. Enter the disease, or complications that caused the deals. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Vascular Dementia /Medical Due to (or as a consequence of) Examiner Stroke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed J physician and as the burial-trans Cardiomyopaty Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 24a. Was an ate has page 2 s autopsy performed? To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒️ No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 X Natural 5 Pending investigation after death.

I Director: Ald in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 29a, Certifier Medical and manner stated 29c. License number 29b. Signature and title of certifier D41978 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 Nader Tavakoli, M.D. 4000 Mitchillville Road, Bowie, MD 20716 31. Date filed (Month, Day, FEB 1 9 32. Registrar's Signature Registrar DHMH 17 Rev 1/2001

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Robert Lee Asberry Month **Physician** Robert Lee Asburry Feb 12, 11:15 PM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bowie Prince George's Larkin Chase Nursing Home If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Dec 17, 1 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Months 420 44 2823 71 1936 Montgomery AL Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 → No Maryland Prince George's Fort Washington 10g. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. African American 16b. Kind of Business/Industry U.S. Airforce Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 724 Chatsworth Drive, Accokeek, MD 20607 20c. Location - City or Town, State Arlington, Virginia 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD Approximate Interval Between Onset and Death Months Months Months 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) Feb 18, 2008

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

Woodlawn, Maryland 21207 22. Name and Address of Facility Loring Byers Funeral Directors Inc 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0066171 February 12 2008 30. Name and adr ress of person who completed cause of death (Item 23a) (Type, Print) 5401 old Court Road Randall Stown MD 21133 Jessa Edelm 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2008 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fh 9877 3-19-08 vt.
State of Maryland? Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician  $P^{\,\mathsf{M}}$ Lambert Adams Freddie 12, 1:25 February 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Montgomery Shady Grove Adventist Nursing Home 8. Date of Birth (Month, Day, Year)
March 27, 1 If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months 1 □ M 2 🛛 F 79 1928 Kentucky March 579<del>-37-</del>4706 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 X Yes 2 □ No Directo Gaithersburg Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20885 221 Booth Street, #115 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 💢 No Specify 2 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public School System Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hazel Jardine Parker Frederick Henderson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21505 Whites Ferry Rd., Poolesville, Maryland 20837 Raymond D. Evans, III / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. Feb. 16, 2008 4 □ Donation 5 □ Other (Specify) Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 W.Montgomery Avenue, Rockville, Maryland 20850 Metu M01193 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 Days a. <u>Pneumonia</u> Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🗓 No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypoalbuminemia autopsy performe 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DDA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

**Physician** /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician Division or Vital Records, P.O. Box 68760 After this 24 hours after death • Funerel Director: within 24

**Funeral** 

Director

an "naturel", or Items 23a or 28a-f show Medical Exaπiner must be notiffed at

permit. Pages 1 and 2 should be filed within 72 hours after Depertment of Health and Mental Hygiene. Important: If Item 27 Is merked other than "naturel", or Item any Injury or other treumetic event, the Medical Exa<u>mines</u>

Baltimore, Maryland 21215-0036

death with the Maryland

State Registrar

5

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Ravi Passi, MD 15225 Shady Grove Road, #208, Rockville, Maryland 20850 32 Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008 9

29c. License number

D28656

29d. Date signed (Month, Day, Year)

February 12, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** 2008 George Norman Armstead /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Harborside Healthcare 8. Date of Birth (Month, Day, Year, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthdav) **Funeral** Months Days Hours Country Min 163tM 2□ F Yrs Feb. 12, Director 77 217-26-3251 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Ansit if Item 27 is marked other than "natural", or items 23a or 28a-f show ant; if Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. Count XX Yes 2 □ No MD Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21202 501 East Preston Street Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify. Q Q 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 driver cab 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Estelle Moore William Armstead 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 501 East Preston Street; Baltimore, MD 21202 Eula Mae Harris / Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o once, 1 I Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Zion Cemetery 02/19/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, MD 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final the chone phos Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examine The law requires that the death certificate be executed mamio sician and burial-trans Due to (or as a consequence of): Box 68760, physician the burial Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 2 No 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform certificate 1□ Yes 2□No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Division or Vital Records, P.O. To the Hospital or Attending Physician: after death. within 24 hours a To the Funeral I

3□ Suicide 4 Homicide

29a. Certifier

(Check only one)

Certification: To Medical

4

State Registrar 29b. Signature and title of certifier

Could not be

determined

MD

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

St Ente 308, BALTIMORE MD SHOA113 A. (tetsten) N. EUTAW

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04560 State of Maryland / Department of Health and Mental Hygiene 11 11 8 1- State Registrar Amend #1, perMD, g877, 3/4/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** : 30 PM Lebruary 200 Mabel Brown /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Nursing timore (enter Th If Under 24 Hrs. 8. Date of Birth Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1□M 20 F Days 217-12-604 Yrs. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 28a-f ehov other traumatic event, it e Medical Examiner must be nutified at Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 12 or items 23a Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Astican America "natural" 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "rephy Injury or other traumatic event, tra Madone. Coflege (1-4or 5+) Elementary/Secondary (0-12) Dental 12 17. Father's Name (First, Middle, Last) Be Gertrud 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Branc Kobin 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place Buriaf 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1eumonia 2 Weeks disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner m Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-trensit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760 Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year Month 4□Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Ension 24a. Was an autopsy performed Vilotty roidism 20 No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner: Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Bonson 320 Avenue 31. Date filed (Month, Day, Year), FEB 1 32. Registrar's Signature State Registrar

/Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Washington Medical Center Glen Burnie 7 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 M 2 XF 216-24-5754 Director Sept. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at Director Maryland Anne Arundel Pasadena with the 10f. Zip Code 21122 10e. Street and Number 1500 Long Point Rd. BERMAN Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 ☐ Widowed 4 ☐ Divorced ear or Dates er than "natur, the Medical B 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Packer 77 Is marked other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Harry Warnick Anna K. Barnhouse ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health as Important: If item 27 is any injury or other trauonce. Harry Berman, son 1500 Long Point Rd. Pasadena, MD. 20b. Place of Disposition (Name of Date 20a. Method of Disposition G1en Haven Cemetery 02-19-08 1払 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 2719 Hammonds Ferry Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mody of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) XYYY /Medical Due to a r as consequence of) Examiner Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine that the death certificate be executed and Due to (or as a consequence of) O. Box 68760, physician Physician/Medical as attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes ed by the a 9 Unknown 9 Unknown signed by t Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ been si Completed has page 2 certificate 25. Was case referred to medical examiner? Be Hospital: 1 🗌 Yes npatient 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death 28b Time of 28a. Date of Injury 28c. Injury at Work? After 1 Certification: (Month, Day Year) the Hospital or Attending Natural Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 ☐ Homicide cal 29a. Certifier

and manner stated.

1. Decedent's Name (First, Middle, Last)

Gladys Hazel Berman

**Physician** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death

20c. Location - City or Town, State Glen Burnie, MD 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne Lansdowne. MD. 21227 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 □Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2 7 No 26. Place of Death Check onl on Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 2008 Name and address of person who completed cause of death (Item 23a) (Type, Print) s Signature **ORIGINAL** 

2. Date of Death

Floring 15

DISO AM

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 X No

Maryland

2008

4c. County of Death

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

Manufacturing

14. Race - American Indian

White

Black, White, etc.

4, 1929

USA

Anne Arundel

**donth** 

Registrar

State

29b. Signature and title of certifier

filed (Month, Day,

FEB 1 9

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Bradshaw Denise 08 February 10:00 2008 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Harbor Hospital 8. Date of Birth Month Dy, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland **Funeral** Months Days Year958 1 □ M 2 XF Hours Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at MD 1X Yes 2 No N/A Baltimore Director 10e. Street and Number 554 Parksley Ave. 10g. Citizen of What Country? <sup>10</sup>21223 filed within 72 hours after death with I Hygiene. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify. ģ Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold Scheff Sophie Chamberlein 2 19a. Informant's Name/Relationship (Type. Print) Susan Renee Parks, sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3620 Coolidge Ave. Baltimore, MD. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Meadowridge Memorial Park 02-21-08 1 Burial 2 □ Cremation 3 □ Removal from State Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) Ambrose Funeral Home of Lansdown MD. 2719 Hammonds Ferry Rd. Lansdown MD. Approximate Interval Between Onset and Deck 21. Signature of Funeral Service Licensee 22. Name and Address of Eacility
Ambrose Funeral Home of Lansdowne 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pancreatic cancer **Physician** ZWUKS disease or conditio resulting in death) /Medical Due to (or as a consequence of): Examiner Bowel perforation 2 weeks Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed Sepsi5 ZWEEKS Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical as the l IF FEMALE use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1∐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No spital: 1 Inpatient 28a. Date of Injury 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? Certification: Natural 2 Accident (Month, Day Year) Injury 5 Pending To the Hospital or Attendil within 24 hours after death.

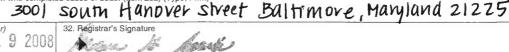
To the Funeral Director: A completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

Registrar

veena ruo md 31. Date filed (Month, Day, Year) FEB 1 9

Nelhar 200MD

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt)

House Staff physicium

esset.

29c. License number

RES 0001

29d. Date signed (Month, Day, Year)

February 08, 2008

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 7 per fth 9876 2-25-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 11:35PM 561 2008 EBRHARY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BON SECOURS BALTIMORE tospit si If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1₩ 2□F MD Director 10-16-1962 215-74-1881 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2 ☐ No Directo MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1221 Ashburton Street 21216 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2☐ No If Yes, GivA X Year or Dates: 1 ☐ Never Married 2 ☐ Mamied Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify ģ Specify. 3 Widowed 4 Divorced Black Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry N/A (Give kind of work done during most of working life. DO NOT use retired) N/A and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade years permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: If item 27 is marked other the any Injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roosevelt J. Bond, II Loretta McCall 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tameka Staley - Daughter 1221 Ashburton Street Balto, MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State Greenmount Cem 2-20-2008 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March East 1101 E. North Avenue MD21202 Balto, 23a. Part , Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im nedia e Cause (Final disease or condition resulting in death) pti **Physician** E /Medical Due to (or as a consequence of): Examiner DNO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner KENAL and The law requires that the death certificate be exect Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ned by the atter detached for u in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Linknown 9 Unknown been signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy 2 1 No 1∐ Yes Hospital or Attending Physician; director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 3□ DOA 1 Impatient 2 ER/Outpatient Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 Pending investigation 1 N lal 1 ☐ Yes 2 ☐ No death. 2 ccident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 003035 30. Name and address of person who pempleted cause of death (Item 23a) (Type, Print) BON SECOURS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar TR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1. Decedent's Name (First, Middle, Last) Month Year **Physician** : SSPM Patrick Brannan February 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sinai Baltimore Hospital Baltimore 1+4 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth Month Bay, Year, 1960 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X**) M 2□ F 220-64-4109 Florida Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at 1 XYes 2 No **Funeral Director** MD N/A Baltimore 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö d other than "natural", or items 23a or event, the Medical Examiner must be 2268 Druid Park Drive 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Known College (1-4or 5+) Construction Worker Roofing Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fili tment of Health and Mental H tant: If item 27 is marked oth Jury or other traumatic even Be Preston Brannan Loraine Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry W. Katz, friend 207 Slade Avenue Pikesville, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【\*\*Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 02/18/08 Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Endocarditis /Medical Due to (or as a consequence of): Examiner drug Chronic MEANS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: sician and K Due to (or as a consequence of): physician Physician/Medical the use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Vital Records, P.O. a□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? the funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Nes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To ō 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t After 1 Division 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

FEB

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 05:48 M Burke Stephen 2 14 08 Christopher /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MD N/A University of Maryland Medical Baltimore Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb 1, 19 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days Hours New Hampshire Months 1 M 2 □ F 001-58-8634 37 Yrs. 1971 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☐XNo Directo Maryland Anne Arundel Severna Park 10g. Citizen of What Country? 10e. Street and Number USA 416 Hucknall Court 21146 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) General Contracting Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Patricia Ann Babcock Christopher Burke ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 416 Hucknall Court Severna Park, MD 21146 China McHold, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 02/18/08 Baltimore, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hematoma Subdural **Physician** 48 hrs resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter ordering Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit requires that the death certificate be executed Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death Month Day Year in the past 12 months? 4☐Pregnant at time of death 1□Yes 2□No Division or Vital Records, P.O. 9 Unknown 9 Unknown 40 Part II. Other significant conditions contributing to deat not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 22 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed Yes 2 No 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner?
1 □ Yes 2 □ No director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 은 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2/11/08 1900 Fall 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide Home Severna 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar Motthew

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

10

Street, Baltimore, MD

21201

30. Name and a viress of person who completed cause of death (Item 23a) (Type, Print)

. S.

32. Registrar's Signature

Greene

Davis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () () 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 4c. County of Death 115 A.M. Kuthona 2 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hipage Rehabilitation Extended care Baltimore 7. Age (In yrs. last birthday) 71 Yrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year **Funeral** Months Days 1**X** M 2 □ F Hours 288-30-5635 18, New Jersey 1936 Director Mar Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore White Marsh Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21162 USA 11540 Philadelphia Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 DX'es 2 □ No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any injury or other traumatic event; the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dry Cleaning Presser 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Natuglia Passa Chester Bergen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robin Zeller, Ex-Wife 129 Dihedral Drive Middle River, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. | 02/19/08 Baltimore, Maryland 21. Signature of Funeral Service Licensee

Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Carcinoma Mamons CRII Luows /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to inimited attecause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to for as a consequence off Completed by Physician/Medical Examiner The law requires that the death certificate be executed for use as the burial-tran and Due to (or as a consequence of): attending physician Division or Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the aid be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy rmed7 2 ☑ No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day To the Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Two Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 Lock Ravey Boulovard, Baltimore, Maryland 212/8 M.D.39

DHMH 17 Rev 1/2001

Registrar

Day, Year)

9

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend 19a, perFH, g876, 2/25/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deatl Month Day Year **Physician** Blamo 23:19 M \_avell 2 16 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Medical Center Baltimore University of If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Months **X** M 2 □ F N/A MD 10 02 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 No Baltimore Director MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21217 1627 West North Ave Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1XXiever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daynielle Blair Lawrence Blamo 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1627 West North Ave, Baltimore, Md 21217 19a. Informant's Name/Relationship (Type. Print) Mother 1627 West North Ave, Daynielle Blair-Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 2/18/08 Baltimore, 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21. Sonature of Funeral Service Licensee mould 21215 . Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e thite Cause (Final Severe **Physician** Prematritu 10 min dis se or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760, physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f Division or Vital Records, P.O. 9 Unknown 9 Unknown signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No 24a. Was an page 2 certificate has autopsy 2 □ No 1⊠ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Certification: or Attending 1 Natural 5 Pending Injury n 24 hours after where the Funeral Director: Af maletely filled in by the funeral properties of 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Registrar

State

Medical

(Check only one)

Sunthia

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

S. Greene

and manner stated

A. matthe.

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mathew

9 2008

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

AU417 64 351918087

Street, Bathmare, MD

29d. Date signed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Day **Physician** 16 2008 Feb. Bates 8:30a M Dorothy Μ. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2 osedaje ranklin Square Hospital Baltmore ( PNTPY 8. Date of Birth (Month, Day, Year)
May 17,1920 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months Min 1 ☐ M 2**½** F 214-05-0444 Director MD Usual Residence of Decedent a or 28a-f show be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Baltimore MD 1 ☐ Yes 2 No Middle River Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 105 Roundup Road 21220 "natural", or items 23a odleal Examiner must b USA hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White ò 3 Nidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Nurse Health event, the 4yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental John Casey Eva Casey ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau once. Lana Walters / daughter 7246 River Drive Road Edgemere MD 21219 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/20/08 Baltimore MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Somature of Pineral Service Licenses Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, of corr shock, or heart failure. List plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Infarction Myocardial /Medical Die to (or as a consequence of): Examiner Due to (or as a consequence of): Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed physician and s the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical death certificate IF FEMALE asn 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? ō Month 5 ☐ Other (specify) signed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has be 2 s autopsy page performed certificate 2 X No Physician: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 1 🗌 Inpatient this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD DW61907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ebs 9000 Franklin Square Drive Bathimore MD 21237 Chukwuma 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible,

State of Maryland / Department of Health and Mental Hygiener

Certificate of Death

3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** BREEDEN 2015 M NORMAN FEBRUARY 13, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hopkins Baltimore Hospital 11) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 VA 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours 1**XX**M 2□ F 65 Yrs. MAR 1,1942 **Director** 212.40.3393 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show in then "naturel", or items 23a or 28e-1 show the Madical Experimentment be notified at 1 ☐ Yes 2 ☐ No Director **ARNOLD** ANNE ARUNDEL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21012 Funeral 810 BUENA VISTA AVE 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status hours after 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 🎗 🔯 Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) NORTHRUP GRUMMAN CLERK 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fi h and Menta! H 7 is markad ot THELMA RICHMOND NORMAN LEE BREEDEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pagas 1 and 2 s Department of Haalth ar Important: If item 27 is any injury or other trau ELEANOR BREEDEN WIFE 810 BUENA VISTA AVE., ARNOLD, MD. 21012 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial XX Cremation 3 ☐ Removal from State \* 4 □Donation 5 Other (Specify) FEB. 15, 2008 BALTIMORE, MD BAYNEW CREMATORY INC. 21. Signature of Juneral Service Licensee 22. Name and Address of Facility
FINK FUNERAL HOME, P.A. 426 CRAIN HWY. S., GLEN BURNIE, MD CRECORY FINK 23a. Part 1. Inter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. Listjonin one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ROOT ABSCESS ONE MONTH /Medical Due to (or as a consequence of). **Examiner** VALUE ENDOCARDITIS TOUR MONTHS AORTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and 6-The law requires that the death certificate be executed ADRTIC REPLACEMENT VALUE Due to (or as a consequence of): signed by the attending physician be detached for usa as the buria Box 68760 ADRTIC Physician/Medical STENOSIS YEARS IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death o 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2∏ No 1 ☐ Yes 2 No 1 Yes of Vital 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑npatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) erei Director: Aftar th filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 5 To the Hospital
within 24 hours a
To the Funerel 29a. Certifier 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2005 8078 FEBRUARY 13, 2008 Mereghia

State Registrar 31. Date filed (Month, Day, Year) FEB 1 9 2008

AJEDIS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johns MENESHIAN 32. Hegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend 9,15,16a-b,18,19a-b,20a-c,22,perty,9876.te201668 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Physician February 9, 2008 9:45 AM Myra Bethune /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Joseph Richey Hospice Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland <del>unk</del> 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours Months 1 □ M 2 🔀 F 214-86-3817 37 Director May 20, 1970 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21201 USA 828 N. Eutaw Street Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-lf Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, unk 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) <del>uni</del>c Elementary/Secondary (0-12) College (1-4or 5+) Local Clubs Dancer <del>unk-</del> 12 unk unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be Marion Anderson truck to 1115 မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 912 N. Carrollton Ave. Paltimore, MD 21217 MD Mr. Joseph Richey Hospic Mr. Joseph Dickens (Friend) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 2/25/2008 Baltimore, MD 4 □ Donation 5 ▼ Other (Specify) in state Greenmount Crematory Russ F.H. P.A. 2222 W. North Ave. W. Baltimore Street 22. Name and Address of Facility Joseph L. State Anatomy Board 655 21. Signature of Funeral Service Licensee Romald S. Wade, Director 21201 21216 23a. Part1. Enter the diseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Baltimore, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) E rathery **Physician** YOU H 10012 /Medical Due to (or as a consequence of): Examiner Bethune 2/9/03 9:45am polatered con if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Physician/Medical Examiner burial-transi Duqto (or asia consequence of): After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by otilis 4 📉 nknown 1 🗌 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? INDY 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

r: 4 | Nursing Home 5 | Residence 6 | other (Specifical Life) Be Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 \ N 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Atatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ò Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 24 and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ٥ Wic West M mal 30. Name and address of person who completed cause of death (Item 23a) (Type, Print LUTAK 32. Registrar's Signature

State

Registrar

Year)

1 9

31. Date filed (Month, Day,

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	Physicia	an	1. Decedent's Name (First, Middle, La	st)				2. Date of De Month	Day	Year	3. Time of I	Death
	/Medic		Thomas E. Brube					January			2:03 A	M M
	Examin	er	4a. Facility Name (If not institution, given 1917, III in a see Description)			4b. City, Town, or			4c. Count		. 7	
	Europal		1817 Tilton Dri  5. Sociat Security Number 6.5		yrs. last birthday)	Silver If Under 1 Year	If Under 24	Hrs R Date of Ric	eh.	gomer		Foreign
	Funeral Director			ERM ADE	33 Yrs.	Months Days	Hours	Min. (Month, Da May 18	y, Year) • 1924	Indi	ice (State or y) .ana	
	p ,	Ì	Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	ention				10	d. Inside Cit	v Limite
	faryia sho	ō	MD Montgon		Silver					,,	1 ☐ Yes	´ 1
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	deat	ner	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H	ispanic Origin	? (Specify Yes or No Puerto Rican, etc.)	14. Ra	ce - America		
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<u>ရ</u>	s 1 and 2 should be tiled within 72 hours after death with the Marylan of Health and Mental Hygiene 1 them 23a or 28a-1 show tiem 21 is marked other then "natural", or items 23a or 28a-1 show other traumatic event, it a Micdical Examinar must be notified at	}	20a. Method of Disposition		0b. Place of Dispo	sition (Name of	!	Date	20c. Location			
Ē	permit. Pages 1 and Department of Heali Important: If Item 2 eny injury or other ones.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Speci		cemetery, crer	natory or other plac	:e)     					
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P.O. BOX 68/60	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	23c. If yes, outcome of pr 1	Fetal death 3   e of death 5	Ectopic pregnancy Other (specify)		one Bird			Ďay Y	ear
Š,	signe d be d	d by	Part II. Other significant conditions	TENED UNITED TO GENERAL BUT HO	a resulting in the u	nderlying cause give	en in Part I.		Yes 2 1		ibly 4 🗆 U	
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5	l or A after Direct In by	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S	pecify)	eet, ractory, office			Street and Num wn, State)	ber or Aurar	HOUSE IVUIN	Der,
	spita nours nerai / filled		29a. Certifier 1 Certifying P	hysician: To the best of m	y knowledge, deatl	n occurred at the tin	ne, date and p	place, and due to the	cause(s) and n	nanner as sta	ated.	
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	0		30. Name and address of person who	completed cause of death	(Intern 23a) (Type,	Print) MI	18	Ill Prince	14.	V/ 0	RMC	2018
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's	Signature &	2000		11	410011	*	7	w
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death -Month Day 5:35 PM February Walter C. Becker 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 X M 2 □ F 214-01-5619 Feb. 25, 1912 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1251 Hillside Rd. 21122 USA 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Parachute Rigger Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Becker Ethel Hevern 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Nancy Cox / Daughter 1502 Jupp Rd., Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State T Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Qther (Specify) Feb. 19. ren Mem. Park 2008 Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral and Cremation Glen Haven Mem. Park 21. Signatu - of her Service Licensee 2nd Ave. SW, Glen Burnie, MD 21061 Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) Due to (1) s a consequence of 00000 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) neum Due to (or as a consequence of) IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐Yes 2☐No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 24a. Was an autopsy performed 2 No 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mapner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? N Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2/☐ Accident

be executed and Box 68760. physician attending p P.O. ò Records, certificate I Division or Vital Hospital or Attending Physician:

burial-tran Physician/Medical the as Certification: within 24 hours after do

To the Funeral Direct
completely filled in by

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

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**Funeral** 

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Me

**Physician** 

/Medical Examiner

Baltimore, Maryland 21215-0036

signed t Completed cate has t Be မ this After Director:

death.

State

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

3 Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifie

A 31. Date filed (Month, Day, Year) Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainter as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

			For State Registrar		State of Ma		Certificate of			ene 2	008	045/3
	511		1. Decedent's Name	(First, Middle, Las	st)				Date of Death     Month	Day	Year	3. Time of Death
4	Physici Medi		Sharon Ka	ay Baumga	rdner				Feb.	15.	2008	12:30 P M
5	Examir		4a. Facility Name (If				4b. City, Town, o	r Location of Death		4c. Cou	nty of Death	
4			5902 Esta	ate Court			Brooklyn			Anne	Aruno	del
	Funeral		5. Social Security Nu			e (In yrs. last birt	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1		9. Birth	place (State or Foreign
в	Director		220-68-51	121	□ м <b>Ж</b> Х F	51	rs.		June 12,			
	pu »	]	Usual Residence of I	Decedent 10b. County		10c. City, Town	or Location					10d. Inside City Limits
	anyla shov	5										1 ☐ Yes 2 ☒ No
	he M 28a-f otific	Director		Anne Aru	ndel	Brook1y			140	- 0111	- 6 14/h - 4 O	
	with t	ä	10e. Street and Num				10f. Zip Code		100	g. Gitizen	of What Cou	intry :
	s 23	Funeral	5902 Esta	ate Ct.	10 Was Dagedont	From in 11 C	21225	lianania Osiaian (Os		SA	Race - Ameri	ioon Indian
	er de item ner n	un.	11. Marital Status	ad OF Manufad	12. Was Decedent Armed Forces? 1 ☐ Yes 2 💢 I		13. Was Decedent of F If Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)		Black, White	
36	rs aft	by F	1 ☐ Never Marrie 3 ☐ Widowed		If Yes, Give Year or Dates:	40	1 ☐ Yes 2 🔀 No	Specify:		Spe	cify: wh	ite
8	hou Itura	ed		15. Decedent's Ed		16a.	Decedent's Usual Occup	pation	10	6b. Kind o	f Business/Ir	- dustry
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	Completed	(Ѕресі	fy only highest gra	de completed)		(Give kind of work done life. DO NOT use retired	during most of work d)	ing			,
212	withi	E	Elementary/Secon	idary (0-12)	College (1-4or 5 2+		terial Cont	rol Speci	alist   N	North	rop Gi	rumman
	il Hygi Hygi other ent, ti	Be C	17. Father's Name (	First, Middle, Last)		· · · · · · · · · · · · · · · · · · ·			e (First, Middle, Ma	aiden Suri	name)	
an	Gerald Gerald								e Paige			
Maryland	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or I									City or To	vn, State, Zi	ip Code)
	1 and 2 Health a em 27 is		Mrs. Dori	s Ritz/	Sister	32	0 Silky Oak	Ct. Lin	thicum. N	4D 21	090	
ē,	is 1 a		20a. Method of Dispe	osition			Disposition (Name of y, crematory or other place				on - City or T	own, State
E					Removal from State  /) Entombre	1	wridge Memo	1	21 2009	2 E	1 lend de	no MD
Baltimore,	- 두달루		21. Signature of For			re meado	22. Name and Addre	ess of Facility Si	ngleton H	Funer	al and	d Cremation
ä	permi Depa Impo any ir		<b>&gt;</b> // -/	16	_	M01411	1 2nd Ave.					Services
H,	uta.	9	23a. Part1 Enter th	disease, or com	olications that caused	the death. Do n	ot enter the mode of dyli					Approximate Interval Between
	Physician		Immediate Cause (F	Final	one cause on each in	a /						Onset and Death
1	/Medical		disease or condition resulting in death)		a. Due to (or as	a consequence of	of):	<i>ar</i> ~ <i>i</i>	(4)/6//			
	Examiner					To	Cuncer ce Trop	eriton	lum			2 years
		Je.	Sequentially list con	ditions, mediate	b. Due to (or as	a consequence o						
V	cuted ad ansil	Examiner	if any, leading to im- cause. Enter Under Cause (Disease or in that initiated events	njury	C.							
ó	an ar		resulting in death) La	ast	Due to (or as	a consequence o	of):					
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical			d							
	rtifica ng ph		IE EEMALE.									
Вох	eath cer attendin for use	Physician/IV	IF FEMALE: 23b. Was decedent		23c. If yes, outcome 1□Live birth	pf pregnancy 2 Fetal death	3 □Ectopic pregnanc	v		23d.	Date of deliv	,
	ed fo	sici	in the past 12 r	months? [No	4□Pregnant at 9□Unknown		5 ☐ Other (specify) _	,			Month	Day Year
P.0	that the de led by the a detached i	h	9 Unknown									
	uires tha signed d be det	by	Part II. Other signifi	cant conditions o	ontributing to death b	ut not resulting in	the underlying cause give	en in Part I.			1	the cause of death?
ord	w requir been si should I	ed							1 Tes	2 □ N	0 31 Pro	bably 4 □Unknown
ပ္ပ	law r as be 2 sh	Completed							24a. Was an autopsy	24	b. Were aut	topsy findings available ompletion of cause of
<u></u>		ĕ							perform	ed? No	death? 1 ☐ Yes	
Vital Records,	nysiclan: The law his certificate has t director, page 2 s	Be (	25. Was case referre	ed to medical				26. Place of Deatl	h (Check only one			
or V	Physic this ce al dire	은	1 ☐ Yes SIZ	Vo	Hospital: 1 ☐ Inpatie	ent 2 ER/Out	tpatient 3 DOA Oth	ner: 4 ☐ Nursing Ho	me 5 Residen	ice 6 🗆	Other (Spec	rify)
0	Attending Ph or death. rector: After th by the funeral		27. Manner of Ceath	5 Pending	28a. Date of Inju (Month, Da		ime of 28c. Injury Wor	ry at rk?	28d. Describe how	v injury oc	curred	
0	endii eath. or: A he fu	atic	2 ☐ Accident	investigation			M 1 □	Yes 2 □ No				
Division	r Att ter de irect irect	Certification:	3 ☐ Suicide 4 ☐ Homicide	determined	28e. Place of inju	ury - At home, fai c. <i>(Specify)</i>	m, street, factory, office		28f. Location (Stre City or Town,	eet and Nu State)	ımber or Rui	ral Route Number,
	iltal o irs af ral D				1				·			
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,	ical	29a. Certifier (Check only	1 X Certifying Ph 2 Medicai Exan	niner: On the basis o	f examination and	, death occurred at the tid/or investigation, in my	me, date and place, opinion, death occur	and due to the car red at the time, da	use(s) and te and pla	I manner as ce, and due	stated. to the cause(s)
	the the makes	Medical	one)		and manner sta	ated.	29c. Licens					
	S S S	-	29b. Signature and t	LAP L	200	60						Day, Year)
			-	ju o	o och	ME	1021	150	176	5/40	ray (-	0, 2000
	10		1	1.	completed cause of d	eath (Item 23a) (	Type, Print)	7.1 10.	P 610	R.	1 4 . 1. 1	5, 200 8 MD 2/06/
			31. Date filed (Month	h Day Year)		ar's Signatu	10501	01010	C 3 1170	00	True,	2/00/
	Sta Regista		51. Date med (World	EB 1 9 2	2008	AND FO	GERLEY.					
	3.51						T set					

			1 - For State Registrar	State of Maryla			nt of Healt e of Dea			giene Reg. No	200	8 04	574
	Physici	an	Decedent's Name (First, Middle, La	st)					2. Date of De	Da	y Yea	3. Time o	of Death
	/Medi		Sonya	L.		Boia	ngiu	F	ebrua	14	4 20	08 03	16 M
	Examir	ner	4a. Facility Name (If not institution, given the second of the security Number of Securit	Kins Hospi:	al last birthday	4b. City,	Balti	More	City	1	. County of D		
	Funeral Director		214-30-2127 Usual Residence of Decedent	ом жог 72	Yrs.	Months		rs Min.	8. Date of Bi (Month, Da July 2	5, 19	935 Wa	Birthplace (State Country) shingtor	n, D.C
	72 hours after death with the Maryland natural', or items 23s or 28s-1 show dical Examires must be notified at	Director	10a. State 10b. County  Maryland Montgom		ity, Town or Lo	ver S	Spring						City Limits
	a or a		10e. Street and Number 3330 North Leist	uso Uomld Dlawi	#E20	10f. Zip	20906				tizen of What	•	
	ne 23	Funeral	11. Marital Status	12. Was Decedent Ever in I		Was Dece		Origin? (Spec	ify Ves or No		ited S	Tates merican Indian,	
Maryland 21215-0036	urs after d el', or iten	by	1 Never Married 2 X Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2  No If Yes, Give Year or Dates:		If Yes, spe	dent of Hispanic cify Cuban, Mex 2∰ No <i>Spe</i> c		ican, etc.)		Black, W		
5-0	"natur	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usu	al Occupation	most of working	2	16b. K	ind of Busine	ss/Industry	
21	within ene. then *	npidu.	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT u	se retired)	nost or working	9	-		iceriais Institute	
12	D 0		12 17. Father's Name (First, Middle, Last)		Of	fice	Manager					приим	•
and	e d la b	Be	John C. Kasow					other's Name ( Olive I			Sumame)		
2	should nd Men marke umatic	ဥ	19a. Informant's Name/Relationship (	Type Print)	10h Maili	na Addense					Town Ctots	e, Zip Code)20	006
Ma	nd 2 should lith and Mer 27 is marke r traumatic		William N. Soller	**								S <b>pri</b> ng,	
<u>6</u>	He He		20a. Method of Disposition	20b.	Place of Dispo	sition (Nar	ne of	Da	te			or Town, State	עויי
Ë	80		1 🗷 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 5 □ Other (Specification Specification Specif	Ge	cemetery cre ate Of	Heave	ether place) EN	Feb.	,	Sil	ver Sp	ring, Ma	rvlan
Baltimore,	permit. Pag Department Important: Il sny injury o		21. Signature of Funeral Service Licen	see	Cemeter	Name ar Obert	Address of Fa	200: phrey F	uneral			kville, MD 2085	
			23a. Part1. Enter the disease, or com	MOO1 plications that caused the deal	th. Do not ent	JU Wes	BE Montgo	omery A	ve., K	OCKV	ılle,	MD 2085	<u>0-2805</u> te
	Physician		Immediate Cause (Final	one cause on each line.						,		Interval Be Onset and	Death
	/Medical		disease or condition resulting in death)	a. Acute pro	MUPLO	UTIC	leuke	.Vrna		-		Z we	6KZ
	Examiner			Mesenter	ر. اُدر	hemi	Ø					1 dag	l .
7	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						0000	
/	nd ransi	Examine	that initiated events	C									
Ő,	ate be executed hysician and the burial-transit	Ä	resulting in death) Last	Due to (or as a conse	quence of):								
8760,	icate be executed physician and s the burial-transit	dica		d		_							
9 ×	eath certific attending p	Physician/Medical	IF FEMALE:	220 14									
Вох	atten for us	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn	aldeath 3	Ectopic pr					23d. Date of a Month	delivery Day	Year
P.O.	res that the de signed by tha a I be detached f	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4☐ Pregnant at time of a 9☐ Unknown	beath 5	Other (sp	өсіту)					,	
σ.	that led by deta		Part II. Other significant conditions of	ontributing to death but not re-	sulting in the u	nderlying c	ause given in Pa	art I.	23a. Did t	obacco i	use contribute	to the cause of	death?
Division of Vital Records,	The law requires that the death certific site has been signed by the attending p page 2 should be detached for use as i	Completed by							10,	Yes 2	□No 3□	Probably 4	Unknown
ခွ	e law has t	ğ m							24a. Was autor	osy	prior t	autopsy findings to completion of	available cause of
<u>=</u>	n: Th icate r. pag								1 ☐ Yes	3 No	death 1 🗆 Y	es 2 No	
₹	sicial certif recto	Be	25. Was case referred to medical examiner?	Hospital:			Other	ace of Death		5210			
ō	Physical distribution	2	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of			Nursing Home	e 5 🗌 Resid d. Describe I			pecify)	
o	ding h. Afte	ţ	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	м	8c. Injury at Work? 1 ☐ Yes 2		u. Describe i	now inqui	ry occurred		
<u> S</u>	Attending Physician: r death. sctor: After this certification the funeral director.	fica	3 ☐ Suicide 6 ☐ Could not be		ome, farm, str				f. Location (	Street an	nd Number or	Rural Route Nur	nher
á	al or A s after i Dire	Certification:	4 Homicide	building, etc. (Speci	fy)	, , , , , ,	,		City or Tou	wn, State	9)		
	To the Hospital or Attanding Physician: The law within 24 hours after death.  Within 24 hours after death.  You the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical (	29a. Certifier (Check only one)  Certifying Ph. 2 Medical Exam	ysician: To the best of my kniner: On the basis of examination and manner stated.	owledge, death ation and/or in	occurred vestigation,	at the time, date in my opinion, o	and place, and death occurred	d due to the at the time,	cause(s) date and	and manner d place, and d	as stated. ue to the cause(	s)
	To th within Fo th	Me	29b. Signature and title of certifier			290	. License numb	er		29d. Da	te signed (Mo	onth, Day, Year)	
			Elizabeth Le	ademan Men	tical No	ctar	PF7-C	000	l l	phri	Mani II	1 7m	
•	17/		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type	Print)	1763-0	,	11	ZUI I	rury P	L COOK	
	17			man. The J	ohns L	lonki	Dr Harn	Hal (001)	North \	Nolfe	Street	+ ZOOF Baltimore MD ZI	287
	Sta	te	31. Date filed (Month, Day, Year)	32 Plagistrar's Sign	ature	-	3 11~P	,, ,,, 0 . 0	1101111		-	17 1 LL 64 1	
	Registra	ar	EER 1 9 20	INS A COLOR	M. As	SAR 1							

DHMH 17 Rev 1/2001

08-01031	
Mildred Brandon	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		tificate of		ia mone	a. Hygierie	Reg. N	lo. 200	8 0457
Physicia	an/	1. Decedent's Name (First, Middle, Las	t)	-			2. Date of Month		y Year	3. Time of Death 1040 hrs
ledical Exami		Mildred Y. Brandon  4a. Facility Name (if not institution, give	a street and sumbor	Ta	b. City, Town, o	or Location of		ary 5, 20	008 4c. County of Death	
		717 Druid Park Drive Apt.	· ·		Baltimore	or Location of	Death		n/a	_
Funeral Director		5. Social Security Number 6. Social Security Number 1	7. Age (In yrs. Ia M 2 F 65		If Under 1 Ye			of Birth (M 13–194	Co	thplace (State or Foreign untry) D.C.
any		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location	on no					10d. Inside City Limits
<b>*</b>	Ļ	MD n/a		1timore						1 X Yes 2 No
Maryland 28a-f show 1 at once.	Director	10e. Street and Number			10f. Zip Code			10g. C	Citizen of What Cou	ntry?
th the ? 23a or notifie		717 Druid Park Lak			2121				USA	Latin Block
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-5 sho injur or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorced	1 Yes 21 No If Yes, Give Year	lf Y€		an, Mexican,	n? ( Specify Yes o Puerto Rican, etc		White etc	ican Indian, Black, n-American
ours af atural xamin	d by	15. Decedent's Education (Specify o	or Dates:	16a. Decedent		ation (Give k	ind of work done	16t	b. Kind of Business/	
36 in 72 h nan "n lical E	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	Waitres		ie. DO ND i	ise retired)	I	Fish Market	
215-0036 be filed within 7 ntal Hygiene. rked other than	mo	12th 17. Father's Name (First, Middle, Last	)			18.Mother's	s Name (First, Mic	idle, Maid	len Surname)	
215 be file mtal Hy rked o	Be	Henry Fisher				Bessie	e Fisher			
Should and Mer is man	5	19a. Informant's Name/Relationship (							, City or Town, State	e, Zip Code)
e, MD and 2 sho fealth and tem 27 is		Tracy D. Thornhill/ D	20b. F	Place of Disposi	ition (Name of o	emetery.	sville, MD		Co. Location - City or	Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 X Burial 2 Cremation 3	Removal from State Lou	rematory or oth don Park	er place) Cemetery		2-9-08		Baltimore,	MD
altir mit. F spartme sportar		4 Donation 5 Other Specify 21. Shap ture of Funeral Service Licer		22. N	lame and Addre	ss of Facility	Wylie Fun	eral H	Hame P.A. of	F Baltimore Co.
	=	23a. Part I. Enter the disease, or comp	Miller	920	O Libert	y Rd., l	Randallsto	wn, M	21133	Approximate Interval
Physician /Medical		failure. List only one cause on e				9, 30011 03 00	adiac of respirate	ry amout,	Shook, or hour	Between Onset and Death
vaminer		Immediate Cause (Final disease a or condition resulting in death)	Due to (or as a consequence of		case				<u>-</u>	
	7	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	f)·						-
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated								
nted id ansit		events resulting in death) Last	Due to (or as a consequence of	f):						
760, icate be executed physician and the burial - transit	Medical	UNPENDED	AMENDED							
760, ficate be g physicist the buri		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregr		tal doath	3 Ectopic	pregnancy/		23d. Date of deliver	ry Day Year
Box 687 death certificate attending	sician/	past 12 months?	4 Pregnant at time of de	ath	tal death : her (Specify)		pregnancy		World	Day Tour
Bo he deat y the at hed for	Phys	1 Yes 2 V No 9 Unknow  Part II. Other significant conditions	9OTKHOWIT	anulting in the u	adoshina cauc	o siven in Pa	#1 23e	Did tobac	cco use contribute to	the cause of death?
, P.O. B ires that the d signed by the	5	Fait ii. Other significant conditions	contributing to death but not re	esuling in the d	indenying cads	e given in ra				bably 4 Vunknown
of Vital Records, ng Physician: The law require offer this certificate has been si meral director, page 2 should b	Completed						24a.	Was an autopsy		utopsy findings available completion of cause of
ecol he law ite has ige 2 sl	dwc				<del></del>	-		performe Yes 2	d? death?	'es 2 No
tal Reco cian: The law certificate has	0	25. Was case referred to medical			26.Pia		(Check only one)			
n of Vital Rec ling Physician: The After this certificate funeral director, page	To B	1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient	-	Other <sub>4</sub>	Nursing Home		sidence 6 🗸 Othe	er: Scene
n of nding Pl th. : After e funera		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	28b. Time of I	· ·   _	njury at Work Yes 2		cribe now	injury occurred	
Division tal or Attendin rs after death. al Director: A	ficat	2 Accident Investigat	28e Place of Injury - At hi	ome, farm, stree			c. 28f. Loca			tural Route Number, City
Div pital o ours aft eral Di	Certification:	3 Suicide 6 Could not determine			-		or To	own, State	e) 	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical (	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	ian: To the best of my knowled r: On the basis of examination a and manner stated.	ge, death occur nd/or investigat	rred at the time, tion, in my opini	date and pla ion, death oc	ice, and due to the curred at the time	e cause(s , date and	) and manner as sta d place, and due to t	ated. he cause(s)
F × F ŏ	Me	29b. Signature and title of certifier	1			nse number			9d. Date signed (M	
		Dem mu	~ K	220)		C.M.E.			ebruary 7, 200	
m		30. Name and address of person who Donna M. Vincenti, MD	Assistant Medical Exar		Penn Stre	et, Baltimi	ore, MD 2120	1		
S	tate trar	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire —	ant 1					

Division or Vital Records, P.O. Box 68760,

within 24

24 hours a

State Registrar

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Pay, Ye

29a. Certifier

melle mo

32. Registrar's Signature

30. Name an addres of person who completed cause of death (Item 23a) (Type, Print)

37

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D41410

JOGINDER

29d. Date signed (Month, Day, Year)

2008

FEBRUARY

TOWN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] § For State Registrar Amend #2, perMD, g877, 3/4/08 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2/13/2008 Day Yea 3. Time of Death Month **Physician** 5:20 <sup>P м</sup> Conway, Joseph Michael /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore
Inder 1 Year | If Under 24 Hrs.
Oths | Days | Hours | Min. Joseph Richey Hospice
5. Social Security Number 6. Sex n/a 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 🗆 F Director 220-30-4761 09/09/1935 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No **Funeral Director** MD n/a Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1600 S. Ellamont St. 21230 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White <u>م</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lineworker Brewerv 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph M. Conway, Sr. Margaret Gurzauskas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1600 S. Ellamont St. Baltimore, MD 21230 Rhoda Conway / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crematory 2/15/2008 Odenton, Maryland 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licensee of mx 1328 Sulphur Spring Rd. Arbutus, Maryland 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) > to mach anier With Merasteses Physician 4 mo. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Medical Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1□Yes 2□No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0035712 al harine S. Hamisin d 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) osph Richey Hospice Ralk 21201 WITAWS Harrison 32, Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 19 Registrar 2008 DHMH 17 Rev 1/2001

**ORIGINAL** 

29c. License number

D0066508

821 N. Eutaw St. Suite 405 Baltimore, Md. 21201

Ali mirebrahimi mo

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

02/17/08

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Ali Mirebrahimi-Tafreshi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death cedent's Name (First, Middle, Last) Month Physician /Medical 4b, City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baitimore -atons vill summitt Kehals rark If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Davs | Hours | Min. (Month, Day, Year) 9. Birthplace (State or Foreign 9.5 North Caroline 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months Days 1**⊠**(M 2□F 218-07-707 Director Usual Residence of Decedent 10d. Inside City Limits should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylas Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director mor 10g. Citizen of What Country? 10e. Street and Number 150 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 √ les 2 □ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Saltimore, Maryland 21215-0036 Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STA ne 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) THORNE amuel ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lenton Ave. 21212 garante 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3 □Removal from State 1 Burial 2 □ Cremation 0 S Kandadstown, MD. 4 ☐ Donation /5 ☐ Other (Specify) 21. Signature Pineral Pervis Lice nee 21225 23a. Party F or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate cause (Final disease 1 condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it are cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner death certificate be executed and burial-tran Due to (or as a consequence of) Physician/Medical the attending pt for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.0. ed by the a detached f 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 3 Probably 4 hknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performer ves 2 certificate has 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 N 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 1 Inpatient Certification: To After this 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide

the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

> State Registrar

Medical

29b. Signature and title of certifier

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Alch

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

2008

State of Maryland / Department of Health and Mental Hygiene 04580 Certificate of Death 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) 2008 FEBRUARY **Physician** 13, 1:55 P. M NORMA M. CHERIGO /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE PARKVILLE 1608 ABERDEEN ROAD 8. Date of Birth (Month, Day, Year, 8/10/1919 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday If Under 1 Year | If Under 5. Social Security Number **Funeral** Days Hours 1 □ M 2 □ F Yrs 217-05-8586 MARYLAND 88 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 28a-f show a or 28a-f show be notified at 1 Yes 2 No BALTIMORE PARKVILLE Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number items 23a 21234 USA 1608 ABERDEEN ROAD **Examiner must** by Funeral 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give hours after 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: WHITE 3√□ Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) within 72 d 2 should be filed within 7 in and Mental Hygiene. 7 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) HOTEL 12TH GRADE OWNER & OPERATOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental. Important: If then 27 Is marken any Injury or any Inj CATHERINE GRAFF CLAUDIO MACCIOLA ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3039 N. CALVERT ST. B2 BALTIMORE, MD 21218 MICHAEL C. CHERIGO/SON 20b. Place of Disposition (Name of cemetery, crematory or other place)
MOST HOLY REDEEMER 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donaltion 5 ☐ Other (Specify) 2/20/2008 BALTIMORE, MD CEMETERY 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service 21286 8521 LOCH RAVEN BLVD. TOWSON, MD 23a Pan1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) accuro /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the conditions of the conditions, if any, leading the conditions of the conditions o Due to (or as a consequence of) Examiner Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 ponths?

1 Yes 2 No
9 Unknown Month for detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s death? perfor 2□ No 1□ Yes 2 N 25. Was case referred to medical examiner? 26. Place of Death Check onl one director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 1 ☐ Yes 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a Date of Injury After (Month, Day Year) Injury 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hours the Funeral Directory determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 15, 2008 174027 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loch Raven Blud Baltimore MD 21235 Thomas Wilson MD 5601 31. Date filed (Month, Day, FEB 1 32. Registrar's Signature State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		_	State of Maryland / Department   For State of Maryland / Department   For FH G8762/20/88	rtificate of Death		ne No2008	04581
	Physicia	ın	1. Decedent's Name (First, Middle, Last)  DOROTHY COTTRELL		2. Date of Death Month FEBRUARY	Day Year 17, 2008	3:00 P.M
	/Medic Examin	-	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	T EDITORICE	4c. County of Death	7.00 1.
			6401 LOCH RAVEN BLVD. APT. 315	LOCH HILL		BALTIMORE	
	Funeral Director		5. Social Security Number  6. Sex 1 □ M 2X F  7. Age (In yrs. last birthday)  83 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Ye) 9/25/1924		ace (State or Foreign try) VIRGINIA
	rland ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Loc	ocation		10	0d. Inside City Limits
	a-f sh	ţċ	MD BALTIMORE LOCH H	ILL			1 ☐ Yes 2X No
	with the Maryland a or 28a-f show be notified at	Funeral Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Coun	try?
	eath v	eral	6401 LOCH RAVEN BLVD. APT. 315  11. Marital Status 12. Was Decedent Ever in U.S. 13.	21239 Was Decedent of Hispanic Origin? (Spi	ecify Yes or No-	USA 14. Race - America	an Indian,
326	72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examiner must be notified at	by Fun	1 TXNever Married 2 □ Married 1 □ Yes 2 □ XNo	Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☐ No Specify:	Rican, etc.)	Black, White, of Specify: WHIT	
5-0036	72 hou natura lical E	ted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation with the kind of work done during most of work	ing 166	b. Kind of Business/Inc	lustry
71	들 등 도 등	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	"" AL	LERT DETECT	TIVE AGENCY
Z   D	filed wit Hygiene other the		12TH GRADE   SECU	RITY GUARD  18. Mother's Name	e (First, Middle, Mai	iden Surname)	
an	ed fall	To Be	HENRY S. COTTRELL		E L. JOHN		
Mary	2 should and Men is marke aumatic	H. (1)	19a. Informant's Name/Relationship (Type. Print) GRANDDAUGHTER	ng Address (Street and Number or Rur	al Route Number, C	ity or Town, State, Zip	Code)
	s 1 and 2 f Health a ftem 27 is		CONTRACTOR OF THE PROPERTY.			D 21236 c. Location - City or To	
Baitimore,	e = 5		1 ☐ Burial , 2 ☑ Cremation 3 ☐ Removal from State	ematory or other place)			
	permit. Pag Department Important: any Injury once.			EMATORY, INC. 2/18 2. Name and Address of Facility TL	Marine I and the second second	TONSVILLE, I FUNERAL H	
n g	Depermination De	j. 70	SI I I I I I I I I I I I I I I I I I I	521 LOCH RAVEN BLV		ON, MD 212	•
			23a. Part I. Enter the disease, or complications that caused the death. Do not en	ter the mode of dying, such as cardiac	or respiratory arrest	,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	c Heart ?	21160	91	Onset and Death
	/Medical Examiner		resulting in death)  Due I. (or s a consequence of):	o puthy			
		ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	3 bound		-	
6	d d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	(			
Ď.	ficate be executed physician and is the burial-transit	EX	resulting in death) Last  Due to (or as a consequence of):				
58/50,	ficate b physic s the b	edical	d				
C. Box t	attending for use a	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
ς, Γ.	w requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the	ınderlying cause given in Part I.	23e. Did tobac	cco use contribute to the	ne cause of death?
Las	quires en sigr uld be	ed by			1 ☐ Yes	2 No 3 Prob	pably 4 Unknown
Hecord	e la has	Completed			24a. Was an autopsy performe	d?   death?	psy findings available mpletion of cause of
VItal		BeC	25. Was case referred to medical examiner?		th (Check only one)		
or <	Physic this ce	P	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie			ce 6 ☐Other (Specif	у)
	ding F	ion:	27. Manner of Death  1 □ Natural 5 □ Pending (Month, Day Year)  2 □ Accident investigation (Month, Day Year)	of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how	injury occurred	
UIVISION	or Attending Physician: after death. Director: After this certific In by the funeral director,	Certification:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, si building, etc. (Specify)		28f. Location (Stree City or Town, S	et and Number or Rura State)	ul Route Number,
	To the Hospital or Att. within 24 hours after de To the Funeral Direct completely filled in by the	edical Ce	29a. Certifler (Check only one)  29a. Medical Examiner: On the bass of examination and/or in and manner stated				
	Fo the vithin 3	Med	Only Signature and the Manday	29c. License number	29d	. Date signed (Month,	Day, Year)
			290. Signature and the order times of the ti	100) 10 C	(	2-18.	- 5009
	7		30. Name and address of person who completed cause of death (Item 23a) (Type Zick Mirky MD, E70)	NChailes St	700	W, noza	· Em
	Sta Registr		31. Date filed (Month, Day, Year)  FFR 1 9 2008  32. Régistrar's Signature	forde			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 14, **FEBRUARY** 2008 7:40 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth April Day, 17ear) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 M XXX F 89 Yrs. Maryland 213-38-8853 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at show 1 Yes 2 No MD Harford Forest Hill 10e. Street and Number Apt. 509 1 Colgate Drive 10f. Zip Code 10g. Citizen of What Country? or Se 21050 USA "natural", or items 23a r death v by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or iten any injury or other traumatic event, the Medical Ex. miner 1 Never Married 2 Married 1 □Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 3 ☐ No white Specify. 3√Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore County College (1-4or 5+) Receptionist 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Catherine Kernan William Dinan, Sr ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Crabb Court-Conowingo, Maryland 21918 Jean Valdivia-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

New Cathedral
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb. 18, 2008 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3 Newport Drive EVANS FUNERAL CHAPEL AND CREMATION SERVICES 09M Forest Hill,MD 21050 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the configuration of the cause (Disease or injury that initiated events resulting in death) Last a a consequence of) Examine P gue The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Por Month Day Yes 2 No 5 Other (specify) detached the 9 Unknown cate has been signed by page 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 No certificate or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 5º Pending Injury after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours at To the Funeral C To the Hospital 29a. Certifier 🔁 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 250 D 3 2279 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 615 W. MACPHAIL ROAD BEL AIR, MD. 21014 31. Date filed (Month, Day, Year) FEB 1 9 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #26, perMD, g876, 2/19/08 Tertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death F BRU ARY Day Physician 16:34PM 5,2008 WILLIAM /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner BALTIMORE AGNES If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Marths | Days | Hours | Min. | Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Days Director VLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Funeral Director HOWARI 10e. Street and Number 10g. Citizen of What Country? Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian, d other than "natural", or Items event, the Medical Examiner m 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 Is marked other than "natural", or Ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 Z No Specify: Completed by 3 Widowed 4 Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Flementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be GREENAR WILLIAM injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Pural Route Number, City or Town, State, Zip Code) COLUMBIA MD. Department of Health Important: If item 27 ANE 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or 4 ☐ Donation 5 ☐ Other (Specify) JR. FUNERAL HOME 21. Signature of Funeral Service Licenses FULTONAVE, BALTO, MD 212 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Myor andial infarchim Aruk thirty minus disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine ned by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ nummia 4. Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed FAILUNE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2⊞No Gastrointes binal Vital 1☐ Yes 25. Was care referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 2 ER/Outpatient 3□ DOA ivision or 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ebruary 5, 2008 mo 319916795 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Meghan Checkler caton Avenue Baltimore 900 South 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

9 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>D</sup>2008 **Physician** Clemens Feb. 16, Рм David Charles 3:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore Oak Crest 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Maryland 1**X** M 2□ F 88 218-09-6295 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State an "natural", or items 23a or 28a-f show Me Acal Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Baltimore Md. 10g. Citizen of What Country? 10e Street and Number USA 21234 8800 Walther Blvd. Pages 1 and 2 should be filed within 72 hours after death v nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 233 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1**X** Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No altimore, Maryland 21215-0036 Specify: White ģ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Barton- Cotton Co. traumatic event, the Printer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Oswinkle Edna Charles Clemens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 is any Injury or other trau 2705 Park Heights Dr. Baldwin, Md. 21013 Ms. Gail Brown/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐Removal from State 2-19-08 Hilltop Service Co. Towson, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** - andiogenic /Medical Due to (or as a consequence of **Examiner** schemic cardiamuppath-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner buriai-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician a the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by critical acrtic stenosis, severe mitral regurgitation 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown hypertension atrial fibrillation 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1□ Yes 2 No certificate Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica tely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 < Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dixon Walther Blud Parhville MD 21234 8300 tosha 31. Date filed (Month, Day, Year, FEB 1 9 2008 32. Registrar's Signature Registrar

			For State of Ma 1 - State Registrar	aryland / Depa <i>Cei</i>	artment of He rtificate of De			iene 2001	8 04585
ľ	Physici	an	1. Decedent's Name (First, Middle, Last) Horace Morris Counts				2. Date of Deat Month February	Day Your	3. Time of Death 5:05 PM
* *** ********************************	/Medic Ехатіп	al	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo		rebruar	4c. County of Dea	
/	LAdillil	ات. ن	Asbury Health Care Cer	nter	Solomons			Calvert	
*	Funeral Director		230-16-6951 ¹¼м 2□F	e (In yrs. last birthday) 84 Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec 14,	, 1923 Vi	rthplace (State or Foreign ountry) cginia
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	a-f sh	ctor	Maryland Calvert	Solom	nons				1 □Yes 2 No
	vith the	Dire	10e. Street and Number		10f. Zip Code 20688	)	1	0g. Citizen of What C	ountry?
	ns 236 must	Funeral Director	11750 Ashbury Circle  11. Marital Status 12. Was Decedent I	Ever in U.S. 13.1	Was Decedent of Hisp If Yes, specity Cuban,		ecity Yes or No-	USA 14. Race - Am	
036	be filed within 72 hours after death with the Maryland Hyglene. Id other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 ☐ Never Married	1943 1943	57	Specify:	Hican, etc.)	Black, Wh	
9500-612	- 3 6	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5	(Give	dent's Usual Occupation kind of work done dur DO NOT use retired)	on ring most of worki	ng	16b. Kind of Business	-
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_	uld be fi fental H rked otl tic ever	o Be	Grady H. Counts		'		. Dicker	•	
Mary	shoul and Me s mark	2	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street and				Zip Code)
χ. Σ	and 2 lealth i m 27 I her tra	12	Kathleen C. Dixon, Daughte		S. Sandga			nicsville,	
Baitimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic e once.		20a. Method of Disposition  1 ☐ Burial 2X Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	Metro Cr	osition (Name of matory or other place) cematory Ir	02/18	3/08	Baltimore	, Maryland
g Rail	permit. Depart Import any inj	l a	21. Signature of Funeral Service Ucolsee Thornas Gregor	2	remation 199 Frederi	ociëty ( ck Road	Of Maryl Baltimo	land,Inc. ore, Maryla	and 21228
	Physician		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir Immediate Cause (Final disease or condition		ter the mode of dying,	such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as	a consequence of):	HEIMER'S	DEME	= NTIA		YEARS
		niner	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury	a consequence of):		.=:			
60,	icate be executed physician and sthe burial-transit	al Examiner	that initiated events C.	a consequence of):					
09/89	ficate physi sthe	edical	d						
C. BOX	the death certifi y the attending   ched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of d Month	elivery Day Year
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VITa	Physician: this certificatel director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatie	ent 2 □ ER/Outpatie	Othor	26. Place of Deat		<i>ne</i> lence 6 ⊟Other <i>(Sµ</i>	necity)
ס	<u>Ş</u> .≅ P		27. Manner of Death 28a. Date of Inju	ry 28b. Time o				ow injury occurred	recity)
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	the Hosp nin 24 hot the Fune npletely fil	Medical	29a. Certifier  (Check only one)  Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	f examination and/or ir	nvestigation, in my opi	inion, death occur	red at the time,	date and place, and d	ue to the cause(s)
	To To T	Σ	29b. Signature and title of certifier		29c. License		2	29d. Date signed (Mo	
}	h		30. Name and address of person who completed cause of o	eath (Item 23a) (Type.		358		FEB. 10	
	9		BHN WEIGEL	M3 - P.	RINCE 1	FREDE	RICK	mj-2	0678
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registr	eath (Item 23a) (Type,	SAR!				

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ai t	Physici /Medic	cal	Decedent's Name (First, Middle, Last)  A. Facility Name (If not institution, give s	ktreet and number)	Ca	( 60 N.C. 4b. City, To		1 ocation of	F	2. Date of Dea Month	Day i (c	Year ZOOE ounty of Death	
	Examir Funeral	ier	The Johns Hopkin  5. Social Security Number 6. Sex	7. Age (In yrs. last		R If Under 1	alt	If Under 2	4 Hrs. Min.	8. Date of Birth (Month, Day Dec 5,	1	N/A	place (State or Foreign intry) rto Rico
	Director  a-f show iffied at	ctor	Usual Residence of Decedent  10a. State    Maryland   Anne Art	10c. City, To	own or Lo	cation ocation	1			Dec 5,	191/	Puer	TTO KICO  10d. Inside City Limits  1 □ Yes 2 X No
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	10e. Street and Number  11 Charles Road  11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	- 1	Was Deceder If Yes, specify	.090 nt of His Cubar	spanic Origi n, Mexican,		offy Yes or No- lican, etc.)	14	USA  Race - Ameri Black, White Specify: Hi:	ican Indian, , etc.
121215-0036	iled within 72 hour lygiene. her than "natural nt, the Medical E)	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	eation 16	(Give life.	dent's Usual C kind of work DO NOT use DMEMAKE	done di retired)	uring most		g (First, Middle,		Own Hor	•
Maryland	should be fi and Mental H s marked ot umatic evel	To Be	Claudino Rosario  19a. Informant's Name/Relationship (Typ.	pe. Print) 1	9b. Mailir	na Address (S		Ra	mona	Rivera	a	orname)  Fown, State, Zi	in Code)
	es 1 and 2 s of Health ar i item 27 is r other trau	i ii	Emma V. Carbone,	Daughter 1	1 Ch		Roa	d Lin	thic		cylan	d 21090 ation - City or T	)
Baltimore,	permit. Pages: Department of I Important: If Ite any injury or of		1 Burial 2 Tremation 3 Re 4 Donation 5 Other (Specify)  21. Signature Funeral Service Unerse Thomas Gregor	Metro	Cre	ematory	ı In	c. 0	2/18 ty 0			,	Maryland nd 21228
8760,	The law requires that the death certificate be executed  A part of the attending physician and the pural-transit is a part of the attending physician and the pural-transit is a part of t	dical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	e of):	er the mode of		g, such as c					Approximate Interval Between Onset and Death
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Division or	To the Hospital or Attending Physician: within 24 nours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, building, etc. (Specify)	farm, str	M eet, factory, c		′es 2□N	-	Bf. Location (S City or Tow		Number or Ru	ral Route Number,
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)	T with	-	29b. Signature and title of certifier  Clocyclic who cor	(m) (tem 23)	a) (Type	€						signed (Month	•
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Beverly A. Chalk 2:11 A M а 12 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Union Memorial Hospital Baltimore 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□M 2√X Months Days Hours Min. 57 212-62-6899 10-19-1950 Maryland Director Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hyglene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at YXYes 2 No Director N/A Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3005 Elm Avenue 21211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes **¾**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No þ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Disabled Disabled 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve once. Nimrod Middleton Chalk Alverta May Marsh ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3005 Elm Avenue Shirley Ann Harris Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Metro Crematory Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2/14/2008 21. Signature Funeral Service Lidensee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Urosepas LWIRCK /Medical Due to (or as a consequence of). **Examiner** 50 years Myeliti Transverse Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician; The law requires that the death certificate be executed the burial-tran attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) signed by the 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?/ /es 2 No After this certificate 1∐ Yes 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending To the Hospin...
within 24 hours after death.

To the Funeral Director: Af investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD Brown AT2438946 February 12, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State

Registrar

Danielle

31. Date filed (Month, Day, Year)

FEB

19

2008

M.D

32. Registrar's Signature

1

Memorial

Hospital

			For State Registrar	State of	Maryland /	-	artment of H		_	giene Reg. No. 2	008	04589
			Decedent's Name (First, Middle)	, Last)					2. Date of De	ath		3. Time of Death
	Physici		Oliver Clifton	Clayton	Īχ				Feb.	Day 14, 2	Year NN8	6:45 P M
and the	/Medio	20.00	4a. Facility Name (If not institution				4b. City, Town, or	Location of Dea			nty of Death	
		Ŭ.	Genesis Elder	Care			Brook1v	n		Anne	Aruno	le1
	Funeral		5. Social Security Number		. Age (In yrs. last		If Under 1 Year Months Days			h		lace (State or Foreign
	Director		218-03-4960	1 XM 2□ F	87	Yrs.	lilonino Bayo	Tiodio IIIII	July 1,		MD	,
	pur »		Usual Residence of Decedent  10a, State 10b, County		10c. City, To	own or Lo	cation				11	0d. Inside City Limits
	sho sho ad at	5										1 □Yes 2 XNo
	the N 28a-f lottfi	Director	MD Anne A	Arundel	Glen ]	Burn:	Le 10f. Zip Code			10g. Citizen o	of What Cour	ntry?
	with la or	ā	7813 Windborn	\nt F			21060					,.
	leath ns 23 mus	Funeral	11. Marital Status	12. Was Deced	lent Ever in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (	Specify Yes or No	USA 14. R	ace - Americ	an Indian,
36	be filed within 72 hours after death with the Maryland that Hyglene. id other than "natural" or items 23a or 28a-f show other, the Medical Examiner must be notified at	by Fur	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	Armed Ford ed 1 ☐ Yes 2 If Yes, Give Year or Dat	2 [ <u>X</u> No	1	lf Yes, specify Cuba 1 □ Yes 2🂢 No	n, Mexican, Puè Specify:	rto Rican, etc.)		lack, White, c <i>ify:</i> Whi	
Maryland 21215-0036	2 hou	pa	15. Deceden	's Education		6a. Dece	dent's Usual Occupa	ation		16b. Kind of	Business/In	dustry
215	in 72 in "in Media	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1	4or 5+)	(Give life.	kind of work done o DO NOT use retired	luring most of wo )	orking			
212	filed withir Hygiene. other than ant, the Ma	ě	6	- College (1		Frucl	k Driver			Truck	ing	
Б	e filed al Hygid other vent, tl	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Na	me (First, Middle,	Maiden Surn	ame)	
<u>la</u>	should be and Mental s marked o	은	Oliver C. Clay	on, Sr.				Unknown	<u>ı</u>			
ar			19a. Informant's Name/Relations	nip (Type. Print)	1	9b. Mailir	ng Address (Street a	and Number or F	Rural Route Numb	er, City or Tow	ın, State, Zip	Code)
			Mr. James Clay	con, Sr./			Leymar Ro					
Baltimore,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from S	tate 20b. Place	e of Dispo etery, cre	sition (Name of matory or other place	e) Febr	uary 14	20c. Locatio	n - City or To	own, State
Ë	Pages Iment of Itant: If ite		4 Donation 5 DOther (S	pecify)			en Memoria			Glen B		
3ali	permit. Pag Department Important: I any injury o		21. Signatur ne I Service	Licensee	W01/11							Cremation
	<b>Φ□ = α ο</b>		promise		M01411		2nd Ave.	-		-	1061	Services
H			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca only one cause on ea	ch line.		er the mode of dying	1 .				Approximate Interval Between Onset and Death
	Physician	ĺĺ	Immediate Cause (Final disease or condition resulting in death)	_a/\	1900	A02	DIAZ	INHA	RCTIC	200		
	/Medical Examiner		resulting in death)	Due to (o	r as a consequence	ce of):						
16		<u>.</u>	Sequentially list conditions,	b.	r as a consequence	) ee nfV						
T	ted nsit	Examine	if any, feating to immediate cause. Enter Underlying Cause (Disease or injury									
V	be executed sician and burial-transit	xar	that initiated events resulting in death) Last	c Due to (o	r as a consequenc	ce of):						
8760,	ate be executed hysician and the burial-transit	dical E		d								
9	ifficate l g physi as the k	edi								-1		
Вох	The law requires that the death certific te has been signed by the attending p tage 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		ome pf pregnancy rth 2 ☐ Fetal dea		Ectopic pregnancy			23d. I	Date of deliv	ery
	deat e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		int at time of death		Other (specify)				Month	Day Year
P.0	by the datached	hys	9 ☐ Unknown									
	igned be det	by F	Part II. Other significant condition	ons contributing to dea	ath but not resulting	g in the u	nderlying cause give	en in Part I.				he cause of death?
ord	w requir been si should I								10	Yes 2□No	3 ☐ Prol	pably 4 Dunknown
or Vital Records,	e law r has be je 2 sh	Completed							24a. Was	osv	prior to co	ppsy findings available mpletion of cause of
<u> </u>		Son							perfo	rmed? 2 No	death? 1 ☐ Yes	2□No
/ita	ician: Th certificate ector, pag	Be (	25. Was case referred to medica examiner?				Ī		eath (Check only o	ne)		
7	Physic this cral dire	၉	1 ☐ Yes 2 ☐ No		patient 2 ER/			4 LU Prursing	Home 5 ☐ Resi			fy)
u u	Attending Physician: r death. ector: After this certific. by the funeral director,		27. Manner of Death 1 ☑ Natural 5 ☐ Pendin		f Injury 28i a, Day Year)	b. Time o Injury	Work		28d. Describe	how injury occ	curred	
Sio	Attend death. ctor: / y the f	cati	2 ☐ Accident investig	not bo	finium Athama	forms of		Yes 2□No	006 1	Cannada and Alvin	anhanan Rus	al Pauta Alumban
Division	or At	Certification:	4 ☐ Homicide determ	ined 26e. Place o	of injury - At home, g, etc. (Specify)	, iaiii, sii	eet, factory, office		City or To		inber or nur	al Route Number,
-	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifyir	g Physician: To the I	best of my knowled	dge. deat	h occurred at the tin	ne, date and pla	ce, and due to the	cause(s) and	manner as s	stated.
	etely	edical		Examiner: On the ba	sis of examination							
	To the Hospital within 24 hours a To the Funeral completely filled	Me	29b. Signature and title of certific	11 11			29c. License	number		29d. Date sig	ned (Month,	Day, Year)
	/		· A	shally	N		22	3530	5	2-	-15-	.08
	16		30. Name and address of person	who completed cause	of death (Item 23	a) (Type,	Print)	2 / ===	1	` `	0 .	
	1)		HSHOK	K CH	ATTER	しづさ	=G, $=$	5927	ANNAI	POLIS	KITH	08
27	Sta	ite	31. Date filed (Month, Day, Year)		giarar Ş Signature	20	1.5.					
	Regist	rar	FFB	1 9 2008	William .	A	E338488					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Col 5:30 PM scar 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Randallstown Baltimore Counti Randallstown Genesis 5. Social Security Number 8. Date of Birth (Month, Day, Y Dec. 18, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Year 1928 Washington, D.C 1**%** M 2□ F 578-40-5799 79 Hours Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Anne Arundel Severn 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7898 Huguenot Court 21144 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑X/es 2 □ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: Black 1 Tes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of College (1-4or 5+) Elementary/Secondary (0-12) Defense Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Oscar Ervin Collins, Sr. Gladys Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7898 Huguenot Court Severn, MD 21144 Mrs. Ann B. Collins/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Cremation Feb 19, 2008 □Donation 5 □ Other (Specify) Stevensville, MD 21. ignature of Funeral Service Licensee 22. Name and Address of Facility
Singleton Funeral and Cremation Services
1 2nd Avenue SW Glen Burnie MD 21061 MO1431 23a. Part1. Enter the disease, or complications that cabeed the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Muasthenia aravis Due to (or as a consequence of): stage rena Sequentially list nonclitions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con ence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Year 4 Pregnant at time of death 5 Other (specify)

**Physician** /Medical Examiner

burial-transit

signed by the attending physician and a be detached for use as the burial-tran

should s

certificate

death.

within 24 hours efter To the Funeral Dire

**Physician** 

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

ir than "netural", or itams 23a or 28a-f shov the Medical Examination must be notified at

other traumatic event,

5

permit. Page Department of important: if any injury or once.

Completed by Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 ie marked other then "netural", or itams 23a or 28a-f show

Baltimore, Maryland 21215-0036

Examiner by Physician/Medical Completed the Funeral Director: After this certific mpletely filled in by the funeral director. Certification; To Be

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

IF FEMALE: 9 Unknown 25. Was case referred to medical examiner?

1 Yes 2 100

27. Manner of Beath

1 Delatural

2 Accident

3 Suicide

4 Homicide

31. Date filed (Month

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

Hospital: 1 | Inpatient

28a. Date of Injury (Month, Day Year)

32. Registrar's Signature

23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 ANO 3 Probably 4 Unknown

autopsy performed 1 Yes 2 D.M

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death Check only one Other: 4 Irsing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 1 Tes 2 No

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year)

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

MD, MPH

5 Pending investigation

6 Could not be determined

0056

28c. Injury at Work?

who completed cause of death (Item 23a) (Type, Print) Randallstown, MD 21133 Sayed MD, MPH Road,

State Registrar

Medical

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 4:00 AM urr February 2008 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital emorial 9. Birthplace (State or Foreign Social Security Number **Funeral** 215-46-521 1 □ M 2 XF Months Hours Balto MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Baltimore 1 XYes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? U.S.A by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12xx 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname Be *larita* Herman N. Curr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto MD 21217 Brother ДV6 lelvin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore 02-16-2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa of Funeral Service License 8144pshurst to Funeral Services N. W Washington Dr. State Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximat Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) 4 hours **Physician** Myocardial Infarction /Medical Due to (or as a consequence of): Examiner COVONAVI Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physician and Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has performed? Yes 2 No certificate To the Hospital or Attending Physiclan: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Depatient 2 ER/Outpatient 3 DOA P Director: After this I in by the funeral dir 28a. Date of Injury 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Confifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AT2438946 MD February 11, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7

Registrar

State

melanie Gerrior mo



Union

memorial Hospital

MO

Certificate of Death

2. Date of Death Month

February 15, 2008

12:55 P M

- State Registrar

Ray D. Crossley, II

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or For Country)
July 20, 1932 Pennsylvania Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months | Days Hours Min. 1₩ M 2□ F 74 178-26-8410 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with it Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or it any inlury or other traumatic event, the Medical Examiner must be not injury or other traumatic event, the Medical Examiner must be not 20906 United States 2609 Beechmont Lane 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Public College (1-4or 5+) Elementary/Secondary (0-12) Pharmacist Health Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ray D. Crossley Alberta Kull 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2609 Beechmont Lane, Silver Spring, Maryland 20906 Elizabeth E. Hiner/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium Inc. 20a. Method of Disposition Date 20c. Location - City or Town, State February 19, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 2008 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert A. Pumphrey Funeral Home cockville, Inc. 300 West Montgomery Avenue Rockville, Inc. Loger M01498 Rockville, Maryland 20850 23a. Part1. Enger the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure /Medical Due to (or as a consequence of) Examiner Septic Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Coronary Artery Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Stage IV sacral Decubitus Ulcer autopsy performed? 1□ Yes 2 No Chronic lymphocytic leukemia 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Pother (Specify) Hospice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No 은 funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural
2 Accident 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 15, 2008 D2261 wi 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Jugo Gircle, Silver Spring, Maryland 20906 1517 Hugo Alan R. Segal 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 () 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** LOU SALLIE **CUSHNER** FEBRUARY 13 11:50P 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2 POMONA EAST, #308 BALTIMORE BALTIMORE 9. Birthplace (State or Country DISTR OF COLUMBIA 6. Sex If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) 07/18/1929 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🙀 F Months Days 577-34-0890 78 Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at MD BALTIMORE 1 ☐ Yes 2 X No BALTIMORE Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2 POMONA EAST, #308 21208 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No WHITE Specify: Specify: 3 Widowed 4 □ Divorced "natural" permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BRIDAL CONSULTANT EVENT PLANNING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HARRY WASSER BERTHA AHRENBERG 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) STACY SAPPERSTEIN / DAUGHTER EVAN WAY, BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 02/17/2008 BALTIMORE HEBREW REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. رىسى)ن 8900 REISTERSTOWN ROAD - PIKESVILLE MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** METASTATIC POMCVECTOC CONCER 2 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to influediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and use as the burial-tra Division or Vital Records, P.O. Box 68760々 Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑No Month Day Year 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 Yes 2 No 3 Probably 4 Unknown chana districtive page 2 should I has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an alsecte autopsy performed? res 2 No certificate 1□ Yes Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA Certification: To After this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No ↓ hours after death. -uneral Director: A 2 Accident filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours ai Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2/14/08 104037 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ん 4000 CLD COUNT NO 32 Registrar's Signature BALTMONE, WO 21208 KAPLAN DR HARRY 31. Date filed (Month, Day, Year) FEB 1 9 State A CARLO Registrar

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State of Maryland / Department of Health and Mental Hygiene  Cortificate of Death											
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es ta	Item r othe		20a. Method of Disposition		20b. Place of	B120 Dales of Disposition (Name of ery, crematory or other pla	ace)	Date	20c. Location - City or	Town, State	
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permit. Pages	Department of results and wetter anytheries are returned; or items 23a or 28a-f show appropriat; I fam 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service L	Retta, Mi	1443				hen D. Lo . Baltimo	ohrmann,PA ore, MD	
ik - 4			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that caused only one cause on each li	the death. Do	not enter the mode of dy	ing, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death	
	/sician		Immediate Cause (Final disease or condition resulting in death)	a	LU	ng CA	ncer			mindes	
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ne deat	the att	Physician/Medica	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown		5 ☐ Other (specify)			Month	Day Year	
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DIVISION OF VITAL INCCOLOS, F.O. BOX 00/00, Note Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death	with the Funeral area useau.  To the Funeral area useau.  To the Funeral area useau.  To the Funeral area useau.  To the Funeral area useau.  To the Funeral area useau.  To the Funeral area useau.  To the Funeral area useau.  To the Funeral area useau.  To the Funeral area useau.  To the Funeral area useau.  To the Funeral area useau.  To the Funeral area useau.  To the Funeral area useau.  To the Funeral area useau.  To the Funeral area useau.  To the Funeral area useau.  The funeral area u	edical	(Check only 2   Madical 5	Evaminary On the bacic of	of examination a	ge, death occurred at the tund/or investigation, in my	oninion death occu	urrod at the time	date and place and du	ie to the cause(s)	
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14			30. Name and address of person v	vho completed cause of	leath (Item 23a)	(Type, Print)	Chart	les St. (	Palto a	11 2120x	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** AVIC more 6 08 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Ingleside Baltimer If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1**2**M 2□F Min. Months Days Hours Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Baltimore 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? maleside USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DQ NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) Store room C 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra Inaleside Are. Balthure MD alals 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State Wasslaun 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 28 Liberty Rd. Randallston 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Foute browA /Medical Due to (or as a consequence of): Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed Oscierot burial-tran and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical as the t IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a detached f 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performed? ∕es 2☑No death? 1 ∐ Yes 2□ No Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 20 No ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: the Hospital or Attending 1 Natural 5 ☐ Pending investigation n 24 hours after with Euneral Director; Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brown 31. Date filed-(Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 3:40 a M R. Davis 2 10 2008 Juanita /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore
If Under 1 Year | If Under 24 Hrs. 3310 Egerton Road 8. Date of Birth (Month, Day, Year) 9-23-1945 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1□M 2√F 62 MD Director 218-44-6916 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notifled at Y⊡Yes 2□No Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 S 3310 Egerton Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Black Specify: Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Forest Haven N/H Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Certified Care Provider or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Harrell Corrine Sutton ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 to Department of Health at Important: If item 27 is any injury or other trau 3313 Egerton Road Balto, MD 21215 Nikita Davis - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-16-2008 Randallstown, MD Memorial Pk\_ March F/H 21. Signature of Funeral Service Licensee 22. Name and Address of Facility East 21202 Warren 1101 E. North Avenue MD 9 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** tastatic /Medical Due to (or as a consequence of): Examiner ertens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a consequence of): Examiner The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant Live birth 3 ☐Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 9☐Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Ho 24a. Was an has performed certificate 1□ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl o e Be Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 2 No 2 ER/Outpatient 3 DOA 1 🗌 Yes 1 Inpatient Certification: To this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Lirector 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar VIVIENNE

31. Date filed (Month, Day, Year)

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TZ

BALTIMORE

21

30. Name and add on of person who completed cause of death (Item 23a) (Type, Print)

MS

32. Registrar's Signature

ROSE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 3:00 A M February Jerry 8 2008 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Timonium
If Under 1 Year | If Under 24 Hrs. Baltimore Stella 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. 12 M 2□ F 61 June 71946 212-48-1919 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "hatural", or Items 23a or 28a-f show any Injury or forther traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Baltimore 10g. Citizen of What Country? 10e. Street and Number Pleasant 21224 1514 Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th ontractor Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be IXON tarold Dusan 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sparrous Paint 20b. Place of Disposition (Name of cemetery, crematory or other place) MP 21219 C+ 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 22. Name and Address of Facility -21-08 Bathmore, any Injury once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Huneral Service Licenses IIAM 1232 Midvalley Dr. Jessup, PA 18434 arch 23a. Part1. Litter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the control Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death cartificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical ttending phor or use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the upderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown سے زروے وا 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has the irector, page 2 s autopsy performed? 1□ Yes 2 No the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPIC 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 🔀 Natural 5 Pending investigation М 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 24

Registrar

State

29b. Signature and title of contifier

Dr. Eddie

31. Date filed (Month, Day, Year)

FEB 1 9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

a 32 Registrar's Signature

Nakhud

2008

0

2300

29c. License number

D15504

29d. Date signed (Month, Day, Year)

2/18/08

Dulaney Valley Rd. Timonium, MD 21093

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year February 16, 2008 **Physician** Richard Davis, Sr. 8:10 PM Bernard /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Co. 33 Lombardy Drive Dundalk If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours **X**X M 2 □ F Yrs. 54 13,1954 216-62-6535 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director Dundalk Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must b United States 21222 33 Lombardy Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ≥ 2 ▼No
If Yes, Give
Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. 2 3 ☐ Widowed 4 🕅 Divorced White Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General Contractor Maintenance 2 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances Marie Snowden Richard Thomas Davis, Jr. ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 33 Lombardy Drive Dundalk, Maryland Terry A. Schunck (Companion) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buria ☐ 2 🖾 Cremation 3 ☐ Removal from State Willtop Service Corp. 2/20/2008 Towson, Maryland 4 Donatio Other (Specify) uneral Service Lic 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature Dundalk, Maryland 21222 7922 Wise Ave. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Metastai y cors /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): s the burial-transit Examine that the death certificate be executed Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760. physician Physician/Medical as attending IF FEMALE nse 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 | Yes 2 NO 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? this certificate has Hospital or Attending Physician: 24 hours after death. the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 esidence 6 Other (Specify) 2 No Hospital: 1 Yes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 7 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Certification: Injury 5 ☐ Pending investigation (Month, Day Year) Natural М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier FEBRUARY D00284 18,2008 PHYSTUTAN D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OLLY PITICADICIPHIA ROAD BACTIMONE PHOLOD WOLLD NOT N Hagistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

08-01309

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 04600

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Diversity in	F	eqistrar 1. Decedent's Name (First, Midd	tle Last)						ate of Death			3. Time of Death
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C)		1a. Facility Name (if not instituti		ımber)		4b. City, Town,	or Location o			4c. Cou	nty of Death	
4		7706 Warsaw Avenu	_			Gien Burn	nie				Arundel	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Y			Date of Birth(	MM/DD/Y	YYY) 9. Birt Foreig	hplace (State or
Director			1 M 2 XXF		Yrs		ays Hours		AY 29.19	95 <i>l</i> L		untry) MD
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be (	EDWARD B. GREENWA	ALDT II					ANN DL				
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MD id 2 sho lith and in 27 is aumati		TONY DUBIEL		SON		ANTELOPE			IENDERSO	N, NV	89077	Town, State
Fe, Hand Heal Heal		20a. Method of Disposition  1 XX Burial 2 Cremati	Domewal		lace of Dispo rematory or o	sition (Name of ther place)	cemetery,	Da	ate	200. L00a	illon - Gity Oi	TOWII, State
altimore, rmit. Pages I ar epartment of Hei portant: If ite				GLEN	N HAVEN	CEMETERY		FEB 20	, 2008	GLEN	BURNIE	, MD
nit. Partme		21 Sidnature of Funeral Servi	e Liona e	)	22.	Name and Add		ty				
Dep Pen Ba	0: 10	A Troops	FINK	M01	148   FI	NK FUNER	AL HOME, HWYS	, P.A. <u>GLEN E</u>	RURN LF	MD 210	061	Y
Physician		K (RECORY) 23a. Plant I. Enter the disease, failure. List only one cau	r complications that	caused the death.	Do not enter	the mode of dy	ing, such as	cardiac or re	spiratory arre	st, shock,	or heart	Approximate Interval Between Onset and
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Box 6876 e death certificate the attending phy ed for use as the	sici	1 Yes 2 No 9 🗸	Links are a	gnant at time of de known	5 (	Other (Specify)				1		
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b.O. that t	à	Part II. Other significant son		, 10 000111 00111111	3	, ,			1 Yes	2 N	lo 3 Pr	obably 4 🗸 Unknown
S,   quires en sig	led ed								24a. Was a		24b. Were	autopsy findings available
ord w rec as bee	를								autop perfor		prior to death?	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death.  **Alber this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed								1 Yes	2 No	1 🗸	Yes 2 No
al F	Bec	25. Was case referred to med					Place of Deat Other				2 4 01	
Vita nysica I direc		examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatie			Nursing I			e 6 🗸 Oth	ner: Scene
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Division  Hospital or Attend 24 hours after death. Funeral Director: teley filled in by the!	<u>                                     </u>	29a. Certifier 1 Certifyin	g Physician: To the	best of my knowled	ige, death oc	curred at the tin	ne, date and principle	place, and di	ue to the caus he time, date	e(s) and r and place	manner as st e, and due to	tated. the cause(s)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical		g Physician: To the Examiner: On the bas and manne	sis of examination a er stated.	and/or investi							Month, Day, Year)
F = F 5	ĮΣ	29b Signature and title of ce	rtifier	Dan			icense numb	EI		i	uary 16, 2	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Kinley Labruny 10/2 /Medical City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and nu Examiner Vanor Health Care rederick Frederick yrs. last birthday) 8 7 Yrs 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. **Funeral** Days 213-18-9167 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show transmatic event, the Medical Examiner must be notified at 1 ☐ Yes 22 No Mount Carroll Funeral Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21771 United 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 250 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) arroll County Elementary/Secondary (0-12) College (1-4or 5+) zachar Scha ublic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be finent of Health and Mental Doweary Slberry ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) Ridge Road Arry, Maryland 2177/ 20c. Location - City or Town, State Department of Health ar Important; if item 27 is any Injury or other trau once. Varbart 30 MOUNT ite Date 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 Removal from State Sykesville, Maryland 1210 21,2008 21. Sign or of Funeral Service Licensee 22. Name and Address of Euneral Service P.d. Pass 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTIA ALZUEIMERS MARAS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a detached f 9 Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 2 1 No 3 Probably 4 Unknown 1 Tyes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed 2 ☑ No Jivision or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the

State Registrar

29b. Signature and title of certific

Date filed (Month, Day,

FEB

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

32. Begistrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

r 28a-f show notified at

a or

r than "natural", or items 23a the Medical Examiner must

traumatic event,

Department of Health Important: If item 27 any injury or other treater.

72 hours after

should be filed within 7. and Mental Hygiene.

12 should be fi h and Mental H 7 Is marked ott

Pages 1 and 2 s ment of Health an ant: If item 27 Is

Maryland 21215-0036

altimore,

Director

Funeral

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Completed

Be

the burial-tran attending p ed by the a certificate has been sirector, page 2 should fter this certificaneral director, I After

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

hours after

Division or Vital Records, P.O. Box 68760,

Examine Physician/Medical Completed by Be 2 Certification: Director; within 24 hours are:
To the Funeral Dir

Medical

State

Registrar

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No 27. Manner of Death

29a. Certifier

(Check only one)

5 Pending investigation 1 X Natural 2 Accident 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital: 1 ☐ Inpatient

28b. Time of 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No

2 ER/Outpatient 3 DOA

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Other: 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

29b. Signature and title of certifier ucano M 29c. License number 1-19400 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

344 University Blvd. West, Ste. 211, Silver Spring, MD 20901 Ernesto Africano, M.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature 1800

State of Maryland / Department of Health and Mental Hygiene 🔱 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dolor Day 3.45 DM **Physician** Chae 2008 phruay /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE N/A GOOD SAMARITAN NURSING HOME 8. Date of Birth (Month, Day, Year) 12/07/1927 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 (2) M 2 □ F 7. Age (In yrs. last birthday) **Funeral** MD 80 217-26-0425 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 77 is marked other than "naturel", or Iteme 23a or 28a-f show traumatic event, the Madical Examinar must be notified at 1 Yes 2 No MD HARFORD BEL AIR Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1306 BENNETT PLACE 21015 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XiYes 2□No KOREA 1 Never Married 2X Married WHITE Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) F<sub>0</sub>0D SALESMAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be es 1 and 2 should be fill of Health and Mental H DiLeo DiMartino Nickola ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lillian DeLeo / Wife 1306 Bennett Place, BelAir, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If its
any injury or ott 1 ₺ Burial 2 □ Cremation 3 □ Removal from State 02/18/2008 BALTIMORE, MD RADOMER VEREIN 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Fyneral Service License 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Mell Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or s a consequence of) Examiner attending physician and for use as the burial-transit the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the s should be detached 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uhknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy 1 Yes 20X No certificete 2) No 1 Yes or Attending Physician: director. 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this To the Funeral Director: After th completely filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 5 ☐ Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours efter deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year)
February 13th 2008 29b. Signature and title of certifiq De Ballimere, Rd-P 30. Name and address of person who completed cause of death (Item 23a) Type, Pring 500 XOCK ROVEW 2LUCK & 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 12:40pM February14,2008 Dypski Grace /Medical Joyce 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 638 South Decker Avenue Baltimore If Under 1 Year Months Days Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Hours Months 1 ☐ M 2 🔀 F Director 217-24-9334 80 June22,1927 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1√Yes 2□No n/a Baltimore City Md. Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21224-3911 U.S.A. 638 South Decker Avenue Race - American Indian. Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 25 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced Year or Dates: Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Houtz Vesta Stiely ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8324 Carrbridge Circle Towson, Md. Michael Dypski (son) 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St.Stanislaus Cem 2-18-2008 Baltimore, Maryland 21. Signature of Fun 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 6.51 0 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be execut. Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day Year 5 Other (specify) signed by the a d be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ⊡ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Ves 2 No this certificate 1□ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 within 24 hours after uses...

To the Funeral Director: After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) State Registrar

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician FELVICEU Ruth Catherine Donoughe-Dillon /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner A.A. Baltimore Washinton Med. Glen Burnie Ctr. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 PA Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 25€F 85 185.14.6795 09.13.1922 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 ☐ Yes 2 No injury or other traumatic event, the Medical Examiner must be notified Director Glen Burnie A.AMD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö U.S.A. 21060 "natural", or items 23a 906 Shamrock Ct. Funeral Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iter any injury or other traumatic event, the Medical Exam 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 25€No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Waitress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry Bickle Showalter Eva Mae Curtin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) elf 906 Shamrock Ct., GlenBurnie, MD 21060
Disposition (Name of Date 20c. Location - City or Town, State Ruth C. Donoughe-Dil .on/ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Chesapeake Crem. 02.13.08 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityCAFA/Stephen D. Lohrmann, PA 8717 Green Pastures Dr. Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on unch line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Wil Se pentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, the attending physician ned for use as the buria Physician/Medical IE FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown been signed by should be detact Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s this certificate 1□ Yes or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient ۴ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Af er 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funeral Cirector: completely filled in by the f in by the 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

FFR 1 6 2008

31. Date filed (Month, Day, Year)

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)



301

Hospital or Attending Physician: 24 hours after death. To the !

Medical

State

one)

29b. Signature and title of certifier

Mpone

Margarita Korell MD. 31. Date filed (Month, Day, Year) and manner stated

Assistant Medical Examiner

Registrar's Signature

30. Name and ad ress of person who completed cause of death (Item 23a)

2008

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

February 9, 2008

304

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U

			1 - For State Registrar	State of Ma		ertificate of			g. No.	
	Physici	an	Decedent's Name (First, Middle, La					2. Date of Death Month	Day Year	3. Time of Death
	/Medi	cal	Eileen C. Eckenr			T		January		10:20 AMM
	Examir	ner	4a. Facility Name (If not institution, given 808 Evesham Aven			Baltin	Location of Death		4c. County of Dea	ith
ı	Funeral Director		214-14-1300	Sex 7. Age 1□M 2∏ F	(In yrs. last birthda) 87 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec 10,	<sup>y</sup> ear) 9. Bir 1920 Ma	nthplace (State or Foreign ountry) ryland
	/land		Usual Residence of Decedent  10a. State  10b. County		10c. City, Town or	ocation				10d. Inside City Limits
	a-fah	ctor	MD		Baltin	nore				1  Yes 2  No
	h with the	Funeral Director	10e. Street and Number 808 Evesham Ave	nue		10f. Zip Code	21212	10	og. Citizen of What Co USA	ountry?
030	be filed within 72 hours after deeth with the Maryland ital Hygiene. Id other than *natural', or iteme 23e or 28e-f ahow event, I'ra Medical Examinar must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ether Armed Forces? 1 ☐ Yes 2 ☑ Note of Yes, Give Year or Dates:	ver in U.S. 13	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No		ecity Yes or No- Rican, etc.)	14. Race - Ame Black, Whi Specify: Wh	ite, etc.
9500-61212	72 ho	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dec	edent's Usual Occup e kind of work done o DO NOT use retired	ation during most of work	ina 1	16b. Kind of Business	/Industry
7	within 72 ene. than *nat	Jd m	Elementary/Secondary (0-12)	College (1-4or 5+	+)	DO NOT use retired ousewife	1)	9	own home	2
	filed Hygid other ent,	e Co	17. Father's Name (First, Middle, Last		11	ousewile	18. Mother's Name	e (First, Middle, M		3
yland		To Be	Joseph Cain				Marie	Butta		
Mar	s 1 and 2 should if Heelth and Men item 27 ie marke other traumatic	1	19a. Informant's Name/Relationship ( Michael Eckenro		19b. Mai		and Number or Rura nam Avenu		City or Town, State, ore, MD 2	Zip Code) 21212
saltimore,	Pages 1 announce of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specif		20b. Place of Disp cemetery, cri	osition (Name of ematory or other place	e)   [	Date 2	20c. Location - City or	Town, State
Dall	permit. Pages Department of Important: If it any njury or o		21. Signature of F. neral S. rv.) Licer Roll S.	Warde, Dire		2 Name and Address tate Anat altimore,	•		Baltimore	Street
	Physician /Medical Examiner	_	23a. Part 1. Enter the disease, or comshock, by heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate	a. Due to (or as a		ater the mode of dyin	4		st,	Approximate Interval Between Onset and Death
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00/00	tificate be ng physici as the bu	ledical		_ d.						
ž	es id	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tii 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	olivery Day Year
rus, r	quires that n signed b		Part II. Other significant conditions of	contributing to death but	, , , ,	underlying cause give	en in Part I.	23e. Did toba		o the cause of death?
	The law requires that the death site has been signed by the etter page 2 should be detached for u	ompleted						24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
<u>a</u>	cian: ertifice sctor, p	Bec	25. Was case referred to medical examiner?				26. Place of Death			2010
5	Physic this c	၉	1 Yes 2 No	Hospital: 1 ☐ Inpatient			4   Nursing Ho		nce 6 Other (Spe	acify)
5	ding f	tion	27. Manner of Death  1 Natural 5 ☐ Pending  INCREMENT investigation	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	Work	rat ⟨? Yes 2 □ No	28d. Describe how	w injury occurred	
	To the Hospitel or Attending Physician: within 24 hours elfer death at the Funerel Director: After this certifical completely filled in by the funeral director,	Certification:		a	y - At home, farm, s (Specify)			28f. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,
	Hospite 24 hours Funerel etely filled	Medical C	29a. Certifier 1 Check only one) 1 Medical Exam	ysicien: To the best of niner: On the basis of e and manner state	examination and/or i	th occurred at the tim	ne, date and place, pinion, death occurr	and due to the car ed at the time, da	use(s) and manner as te and place, and du	s stated. e to the cause(s)
	ro the	Me	29b. Signature and title of certifier	and marrier state	<b>5</b> u.	29c. License	number	29	d. Date signed (Mont	th, Day, Year)
			Watto 2	2. 26.	nt 191	D DO	012020	9 1	Feb 8 :	8 000
			30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type	, Print)	1-09	t	10.0/	TOUSON
			WALTER P.	WELZ	ANTI	ND 1	500 050	ERPR	10/18/	07 MD
	Sta Registr		31. Date filed (Month, Day, Yeldr) FEB 1 9 20	32 Registrar	s signature					2120

			For State	State of Mary		partment of ertificate of			100	000	0.1	c 0 0
	2. 1		Registrar     Decedent's Name (First, Middle, La	ust)		Crimoate or	Dealli	2. Date of Dea	Reg. No. 2 3. Time of			f Death
	Physici Medi		LARRY	Е		<b>ELLER</b>		FEBRUAR	RY 12	2008	5:50	$A^{M}$
	Examir		4a. Facility Name (If not institution, given				or Location of Deat	h		unty of Death		
		200	STELLA MARIS HO 5. Social Security Number 6.3		In yrs. last birthda	TIMONIU		8. Date of Birt		TIMORE		or Foreign
	Funeral Director			1 X M 2 □ F	60 Yrs	Months Days			v. Year)	Cou	place (State intry)	or roreign
	0		Usual Residence of Decedent			1						
	show	5	MD BALTIM		0c. City, Town or RFTS	TERSTOWN					10d. Inside C	ity Limits
	the N 28a-f notifie	Director	10e. Street and Number			10f. Zip Code			10a Citizen	of What Cou		
	3a or	Ö	10933 BASKERVIL	LE ROAD			136			USA	,	
Ė	ems 2	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 1	3. Was Decedent of If Yes, specify Cul		Specify Yes or No- to Bican, etc.)	14.	Race - Ameri Black, White		
а•ш 36	s after	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 No If Yes, Give		1 □ Yes 2 💢 No		,,		ecity: WH		
5:50 a 215-0036	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed b	15. Decedent's E	Year or Dates:	16a, De	cedent's Usual Occu	pation			of Business/Ir		
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2008 and 2	be od o	Be	17. Father's Name (First, Middle, Last LOUIS	")	ELLER		18. Mother's Nar	me <i>(First, Middle,</i> !	Maiden Sui	rname) SMIT	·⊔	
- 10	should and Men marke	မ	19a. Informant's Name/Relationship	(Type Print)		ailing Address (Stree			ar City or To			
12, Mary	nd 2 suith ar 27 is r trau		SONDRA ELLER /			933 BASKE						.36
FEBRUARY 3altimore,			20a. Method of Disposition	70	20b. Place of Dis	sposition (Name of	ace)	Date	20c. Locati	ion - City or T	own, State	
REC.			1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	fy)	BETH IS	ODESH RAEL CONG	. ; 02/1	.5/2008	BALT	IMORE,	MD	
FEB Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Live	nsee		22. Name and Addr	ess of Facility S	OL LEVIN				
-	H H H W O		23a. Part1. Enter the discussion and	De Mul	Med Do not		STERSTOWN			VILLE,		
6	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		omer are mede or dy	ing, odon do odraid	o or respiratory ar	1001,		Approxima Interval Be Onset and	tween Death
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8760,	cate be executed physician and the burial-transi	dical		<b>d.</b>			_					
9	ertifica ng ph	Wedi	IF FEMALE:									
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o.	the de / the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tim 9□Unknown	ne of death	5 ☐ Other ( <i>sp</i> ec <i>ify</i> ) _					,	
ر. ح	The law requires that the death certifice to has been signed by the attending I age 2 should be detached for use as	by Ph	Part II. Other significant conditions	contributing to death but n	ot resulting in the	underlying cause gi	ven in Part I.	23e. Did to	bacco use	contribute to	the cause of	death?
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ELLER Record	law re as be	Completed						24a. Was autop	an 2	4b. Were auto	opsy findings	available
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LARRY or Vital	sician: The law s certificate has t lirector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		Ot	her	ath (Check only o				7
	Physer this eral dii	. To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpat	of 28c, Inju	4 LI Nursing F	lome 5 ☐ Resid			fy) HOS	PICE
<u>io</u>	ath. rr: Afte	atior	1X Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Ye	ea <i>r)</i> Injur		ork? ]Yes 2∐No					
Division	r Atte ter dea irecto irecto	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of injury building, etc. (5	- At home, farm, Specify)	street, factory, office		28f. Location (S City or Tow		lumber or Rur	al Route Nur	nber,
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	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certification is the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director director.	Medical	29a, Certifier  (Check only one)  LX Certifying PI  2 Medical Exa	nysician: To the best of m miner: On the basis of ex and manner stated	amination and/or	investigation, in my	opinion, death occi	e, and due to the our urred at the time,	cause(s) and date and pla	d manner as s ace, and due	stated. to the cause(	s)
	To the within To the complete	Me	29b. Signature and litle of certifier			29c. Licen	se number		29d. Date si	igned (Month,		
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	15		30. Name and address of person who	·	, , , , ,	. ,			-			
V	,	to.	DR. TARIO MAHMOO  31. Date filed (Month Day, Year)	D 2300 DULA 32 Registrar's	NEY VAL	LEY RD.	TIMONIUM,	MD 2109	93			
	Sta Registr	ar -	FEB 192	2008	Ball	hopeks						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Day Month **Physician** Featherstone David 21:46 February 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sinai Itospital of Ballinon N/A Ballimore City If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, 05 27 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 247.36.4138 1 XM 2 F 87 50 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. Counfy r 28a-f show notified at Baltimore 1 Yes 2 No Director Baltimore, Maryland 21215-0036 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ns 23a or must be r 3509 W. Garrison Avenue 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. Examiner 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ò 1 ☐ Yes 2 XNo Specify Black Specify: þ 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Driver 2nd grade marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Suri Be Featherstone 13011er ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willie Mae Featherstone/Wife 3509 Gamson Avenue Batto. MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If it any Injury or conce. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 02 23 08 Windsor Mill, MD King Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wough n C. Greene Funeral Sowices 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Road Randallstown MD 21133 Immediate Cause (Final disease or condition resulting in death) **Physician** Aute myocardia /Medical Due to (or as a consequence of): Examiner coronerry ontern Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed ician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the s 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Hinknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Huper tension page 2 autopsy perform certificate 2010 To the Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -000 Februery - 17. n who completed cause of death (Item 23a) (Type, Print) rsgn wholeo Bose Satrayi Sinai Hospital . Registrar's Signature 31. Date filed (Month State 2008 Registrar

KNOWN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend 20a-c, perFH, g876, 2/19/08 TT Certificate of Death 1461 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Louise Ford Vanessa 10:15a<sup>M</sup> 02 2008 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6611 Knottwood Ct. Baltimore if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 🕅 F 50 215-76-6092 Director 57 24 Md 0.8 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nert of Heatth and Mental Hygiene. nt: if them 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits r 28a-f show notified at 1XYes 2 No Director MD NA Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ral", or items 23a or Examiner must be 6611 Knottwood 21214 U.S.A. Funeral Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify. Black ģ 3 Widowed 4 Divorced Completed er than "natur, the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant Private 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Ford Helen Blount ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2106 Flintshire Road, Baltimore, Md 21237 Lisa Bryant-Daughter item 27 20b. Place of Disposition (Name of Centrely Crematory of the Place)

Motro Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any injury or o once, Randallstown, MD en- 3 Removal from State 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Acensee Home mpsm 21215 4300 Wabash Ave, Baltimore, 23a. Part1. Inter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shoot or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical e attending ph d for use as th IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 ☐Live birth in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a I Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 🗌 No 3 ☐ Probabiy Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy 1 Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 Tes 2 N 2 ER/Outpatient 3□ DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manne Leath 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d Describe how injury occurred Injury 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. s after death 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier 1 🖾 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of pers

Year)

31. Date filed (Month, Day,

Homos M2120

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death (Item 23a) (Type, Print)

38. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend #3, perMD, g876, 2/26/07 TT Certificate of Death

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Faison 02 09 2008 Theresa /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Bon Secour Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🔀 F Yrs. 42 12 TX 27 65 214-88-3668 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. XYes 2 □ No Director MD NA Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2708 West Franklin Street 21223 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Security Officer City Schools 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Be ( Oliver Johnson Bevlah Mae Faison 21223 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2708 West Franklin Street, Baltimore, Tyrone Jones-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐Removal from State King Memorial Park 2/16/08 Randallstown, Md 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. Immediate Cause (Final disease or condition **Physician** disease or condition HONR /Medical Due to (or as e consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine executed burial-tran Due to (or as a consequence of) attending physician for use as the buria Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy Month in the pest 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Tes 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely f (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPHI BMI ST. BATIMA 1940W. MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

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Baltimore,	permit. Deperting any inj		21. Signature of Funes   Service Licens		22. Name and Address Eckhardt Fi 3296 Charmi	uneral Char	el, P.A. Mancheste	r, Maryla	and 21102
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<u>₹</u>	sician certifi rector	Be	25. Was case referred to medicat examiner?  Hospital:		Outpatient 3 DOA Othe	26. Place of Death (C			
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10	7		30. Name and address of person who completed cause Harper Poursurya HD 2	se of death (Item 23a)	) (Type, Print)	nostead	S OH,		
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3	Registr		FEB 1 9 2008	egistrar's Signature	A SOLES				

			State of Maryland / Department of Health State Registrar  Amend Items 10a,b,c,d,f per inf 2881 077	and Mei 11/08dl	ntal Hygid <b>1b</b>	ene g. No. 2008	04614
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	Funeral Director	ner	Social Security Number   6. Sex   7. Age (In yrs. last birthday)   If Under 1 Year   RE der 24 Hrs. 8.	Date of Birth (Month, Day, ) 2/17/19	4c. County of Dea	N/A rthplace (State or Foreign ountry) MD	
	e Marylaı <b>3a-f show</b> tified at	ctor	10a. State FL BALTIMORE 10b. County Dade OWINGS MILLS	lale Bea	ch		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
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5-0036	be filed within 72 hours after death with the Maryland tital Hygiene.  Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	If Yes, Give 1 ☐ Yes 2 🗓 No Speci		/ Yes or No- an, etc.)	14. Race - Ame Black, Whi Specify:	
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Baltimo	permit. Pages Department of Important: If i any injury or once.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensea  8900 REISTERS	02/17/2 cility SOL	LEVINS	FINKSBURG ON & BROS	., INC.
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5	To the Hospital or Attend within 24 hours after death. To the Funeral Director: 4 completely filled in by the fi		building, etc. (Specify)  29a. Certifier  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date.	and place, and	City or Town, S	State)	s stated
	To the Hovithin 24 I	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deand manner stated.  29b. Signature and title of of filter  29c. License number	leath occurred a	at the time, date	e and place, and due	e to the cause(s)
	ملا		30 Name and address of person who completed cause of peath (from 23a) (Froe, Print)	8/60	)	2/14/	2008
	Stat	to.	30. Name and address of person who completed cause of reath (fem 23a) (Type, Print)  22 Could Clew Tuet Ball More  31. Date filed (Month, Day, Year)  32. Registrar's Signature	MD.	21201	+ =   K	MD, PhD
	Registra	- 4	FEB 1 9 2008 Sie & Speck				,

DIANNA GARRISON
Division or Vital Records P.O. Box 68760

			1 - For State Registrar	oi waryiand	_	ificate of Dea	tn and Mental F ath	iygien Reg. N	- Z U U Ö	04615
	Physici		1. Decedent's Name (First, Middle, Last)  Dianna Clarice G	arrison			2. Date of Month Febru		4, 2008	3. Time of Death 7:28 PM
	/Medic		4a. Facility Name (If not institution, give street and n			4b. City, Town, or Loca			c. County of Death	n
•		\$3	Stella Maris Hos	<u> </u>	4 fo i-4fo -41	Timonium  If Under 1 Year   If Un	Baltim			
	Funeral Director		5. Social Security Number 212-46-7686  Usual Residence of Decedent  6. Sex 1 □ M 2 □ ▼ F	7. Age (In yrs. last		Months Days Ho	nder 24 Hrs. 8. Date of (Month) Urs Min. Dec	Day, Year	)   Cot	nplace (State or Foreign untry) yland
	yland Iow		10a. State 10b. County	10c. City, T	own or Loca	ation				10d. Inside City Limits
	e Mar 3a-f sh tified	ctor	Maryland N/A		Ba]	timore				1XYes 2□No
	with the	Dire	10e. Street and Number 435 South Ellwood Avenu	0		10f. Zip Code		10g. C	itizen of What Co	untry?
	ms 233	Funeral Director		cedent Ever in U.S.	13. W	21224 as Decedent of Hispani	ic Origin? (Specify Yes or exican, Puerto Rican, etc.)	No-	USA 14. Race - Amer	
0000	permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: I fliem 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ※ Married 1 ☐ Never Married 2 ※ Married 1 ☐ Yes, ( 3 ☐ Widowed 4 ☐ Divorced Year or	2 X No Give		Yes, specify Cuban, Me □ Yes 2 <b>⊠</b> No <i>Sp</i> e			Black, White	hite
2	72 ho "natur dical	eted	15. Decedent's Education (Specify only highest grade completed	) 1	16a. Decede (Give ki	nt's Usual Occupation ind of work done during O NOT use retired)	most of working	16b. I	Kind of Business/	Industry
7	within ene. than ' he Me	Completed	Elementary/Secondary (0-12) College	(1-4or 5+)		Coordinato			Boatin	ıg
alla	e filed al Hygi other vent, t	Be C	17. Father's Name (First, Middle, Last)			18. N	Mother's Name (First, Mid	dle, Maide	n Surname)	
<u> </u>	ould by Menta arked atic e	To	Donald Harry Insley				Betty Jan			
Z Z	12 sho h and 7 is m traum		19a. Informant's Name/Relationship (Type. Print)		_		J A	-		
ກຸ	Healt Healt tem 2		William R. Garrison, H			DUTD LITWOO  atory or other place)	d Avenue Ba		ocation - City or	
5	Pages lent of nt: If if		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	n State		natory or other place)	02/15/08	Ba	ltimore,	Maryland
Dallillor	permit. Departrimporta Importa any Inju		21. Signature of Funeral Service Licensee  Thomas Gregor				ciety Of Ma k Road Balt			
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause or	caused the death. I					- 1	Approximate Interval Between
F	Physician		Immediate Cause (Final disease or condition resulting in death)	esay -	130	VZSS				Onset and Death
	/Medical Examiner		Due to	o (or as a consequen	nce of):					
	9-4-	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	o (or as a consequen	nce of):					
	ecuter and -transi	Examiner	that initiated events	o (or as a consequen	and of):					
9	icate be executed physician and s the burial-transit	SalE		o (or as a consequen	ice oij.					
00	E 00 cc	<b>l</b> edical							j	
O. DOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?	utcome pf pregnancy e birth 2 □ Fetal de gnant at time of deat mown	eath 3⊟E	Ectopic pregnancy Other (specify)		-	23d. Date of deli Month	ivery Day Year
,	s that ined by e deta		Part II. Other significant conditions contributing to	death but not resultir	ng in the uno	lerlying cause given in f	Part I. 23e. D	id tobacco	use contribute to	the cause of death?
cords,	equire en sig ould b	ted t	brain office	5, 5			1	☐ Yes	2  No 3  Pr	obably 4X Unknown
ביים ויינים br>היינים ויינים	The law r ate has be page 2 sh	Completed by					a	/as an utopsy erformed? es 2 <b>X</b> IN	death?	topsy findings available completion of cause of 2 \( \text{No} \)
10	certific ector,	Be	25. Was case referred to medical examiner?  1 To Yes 2 TO No. Hospital: 1 To Yes 2 TO No.			Othor	Place of Death (Check or			
5	g Phys er this eral dii	7: To	27. Manner of Death 28a. Dat	e of Injury 28	NOutpatient Bb. Time of	3 DOA 28c. Injury at Work?	☐ Nursing Home 5☐ F 28d. Descr		6XIOther (Specury occurred	city) HOSPICE
5	ath. ath. or: Afte	atior	2 Accident investigation	onth, Day Year)	Injury	M 1 ☐ Yes	2 □ No			
	al or Atte s after de al Directo ed in by tt	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined bui	ce of injury - At home ding, etc. (Specify)	e, farm, stree	et, factory, office		n (Street a Town, Sta		ıral Route Number,
:	ne Hospit n 24 hour ne Funera oletely fille	Medical (	29a. Certifier (Check only one)  1 X Certifying Physician: To t 2 Medical Examiner: On the and ma							
1	To t To t	Ž	29b. Signature and title of certifier	-71	)	29c. License num	nber S C S	29d. D	ate signed (Monta	
	10		30. Name and address of person who completed ca  DR. EDDIE NAKHUDA 230	use of death (Item 23			MONIUM, MD 2	1093		
	Sta		31 Date filed (Month Day Year) #82	Registrar's Signatur	e					
	Registr	ar	FEB 1 9 2008 43	Fin for	A CONTRACTOR OF THE PARTY OF TH					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

08-0 Kerr

01101	_	Please Type or Print in Black Indelible Ink. Ensure All Copies State of Maryland / Department of Health and Mental Hy	giene	e. 201	18 0461
mia Rache Hai		For State Control of Death	Reg. No	£_ V	
Physician	Re		2. Date of Death Month Day	1	3. Time of Death 1530 hrs
Priysiciai diçal Examin		Larmin Rache Hair	Month Day February 7, 20	c. County of Death	10001110
	4:	a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Beltimore	\ \frac{1}{2}	N	A
		1834 Bolton Street	8. Date of Birth (MI)		hplace (State or
Funeral	5	Social Security Number 6. Sex 7. Age (iii yis, last birthday) Months Days Hours Min.	1	Foreig	n untry) M
Director	0	215-02-2044 1 M 2XF 25 Yrs. Yrs.	Mug.15,	1100	
y	_	Sual Residence of Decedent   10c. City, Town or Location   10c. City, Town or Location			10d. Inside City Limits
ом япу	]	Md N/A Ratimore			1 Yes 2 No
yland a-f sh	흸	Oe. Street and Number	10g. C	Citizen of What Cour	ntry?
death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10211 Rolling St 21217		USE	Plack
vith the s 23a e noti		12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Sp. 13. Was Decedent of Hispanic Origin? (Sp. 14. Wartial Status)  15. Was Decedent of Hispanic Origin? (Sp. 15. Was Decedent of Hispanic Origin?)	ecify Yes or No- Rican, etc.)	14. Race - Amer White, etc.	ican Indian, Black,
eath v	Funeral	1 X Never Married 2 Married 1 Yes 2 X No		Specify: R	not
	ð F	3 Wildowed 4 Divorced If Yes Give Year or Dates:  1 Yes 2 No specify: 1 Yes 2 No specify: 1 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of vital properties)	work done 16t	b. Kind of Business	Industry
nours a	ᇗ	during most of working life. DO NOT use reti	red)		4
16 n 72 h nan "r	ig ig	(2) Ascendaline Tech	nician	Solo C	up Co.
withi withi giene.	Completed	17. Father's Name (First, Middle, Last)	e (First, Middle, Maid	len Surname)	
21215-0036 unid be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she ic event, the Medical Examiner must be notified at once	BeC	Charles B. Hair Leci	e A.	White	e Zin Code)
e, MD 21215-0036  I and 2 should be filed within 72 hours after Health and Mental Hygiene. Tilem 27 is marked other than "natural", r traumatic event, the Medical Examiner	ᆰ	19a. Informant's Name/Relationship (Type, Print) (mother) 19b. Mailing Address (Street and Number or	Rural Route Number	1 / Ho M	1 21218
MD d 2 sho lth and n 27 is aumat		MS. Lecte White 606 F, Gutty and 20b. Place of Disposition (Name of cemetery,	Date 2	Oc. Location - City of	r Town, State
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Iant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.		20a. Method of Disposition  1   Burial   2   Cremation   3   Removal from State   Crematory or other place)	16/2008	landa.	une, Md.
altimore, rmit. Pages l at spartment of He uportant: If ite		4 Donation 5 Other Specify:			"
Baltimo permit. Pag Department Important: injury or of	- 1	21. Signature of Funeral Service Licenses	RATH	Home &	1
		23a. Part I. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac	or respiratory arrest,	, shock, or heart	Approximate Interval Between Onset and
Physician ** 'Medical	- 1	allure. List only one cause on each file.			Death
aminer	- 1	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):			
		Sequentially list conditions, b.			
	miner	if any, leading to immediate cause. Enter Underlying Cause			
ıt	~ ~ I	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
cecuted n and - fransit	cal Ex	d.			
), be exesician	dic	UNPENDED AMENDED		23d. Date of deliv	97.6
Box 68760, death certificate be exthe attending physician ed for use as the burial.	Z/M	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic preg	nancy	Month	Day Year
x 68 h certi tendin use a	icial	past 12 months?  4 Pregnant at time of death 5 Other (Specify)			
BO) c deatl the att	Physician/Medi	1 Yes 2 No 9 V Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death?
ords, P.O. B w requires that the de s been signed by the should be detached:		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in act.	1 Yes	2 V No 3 F	
S, F luires an sign lid be	ed		24a. Was ar autops		autopsy findings available to completion of cause of
ord aw rec as bee 2 shou	p e		perform	ned? deatl	1?
Rec The I	Completed by	26.Place of Death (Che	(2.2)		
/ital Rec ysician: The l his certificate l director, page	Be	Inpallent 2 Livodipation 5	-	Residence 6 🗸 C	ther: Scene
Division of Vital Records, tan or Attending Physician: The law require ranger death.  al Director. After this certificate has been siled in by the funeral director, page 2 should te	6	1 ✓ Yes 2 No  27. Manner of Death 1 Natural 5 Poeding FOUND:  1 Natural 5 Poeding FOUND:  28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?  FOUND:  1 Yes 2 ✓ No	28d. Describe h	ow injury occurred en, stabbed, a	nd cut
nding Pl th.	ioi	5 Pending Eph 7 2008 1 1522 hrs	·		
isio Atter er dear rector	icat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	or Tourn St	tata\	r Rural Route Number, City
Div ital or ral Di lled ir	Certification:	determined (Specify) Townhouse / Rowhouse		treet, Baltimore,	
Hosp 24 hou Fune telv fi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, (Check only one) 1 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, (Check only one) 1 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, (Check only one) 1 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, and (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation and (Check only one) 2 Medical Examiner:On the basis of examination and (Check only one) 2 Medical Examiner:On the basis of examination and (Check only one) 2 Medical Examiner:On the basis of examination and (Check only one) 2 Medical Examiner:On the basis of examination and (Check only one) 2 Medical Examiner:On the basis of examination and (Check only one) 2 Medical Examiner:On the basis of examination and (Check only one) 3 Medical Examiner:On the basis of examination and (Check only one) 3 Medical Examiner:On the basis of examination and (Check only one) 3 Medical Examiner:On the basis of	and due to the cause ed at the time, date a	e(s) and manner as and place, and due	to the cause(s)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the this certificate has been signed by the attending physician To the Funeral Director. After this certificate has been signed by the attending physician completely tilled in by the funeral director, page 2 should be detached for use as the burial	Medical	and manner stated.		29d. Date signed	(Month, Day, Year)
+ × + 5	Ž	29b. Signature and title of certifier  O.C.M.E.		February 8, 2	8008
<b>V</b>		1/a/11/10 6-			
17		30. Name and address of person who completed cause of leath (Item 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
	<u> </u>	21 Date filed (Month Day Year) 32. Registrar's Signature	OCME		

Registrar

			For State Registrar	State of Maryland		artment of He rtificate of L			iene <sub>eg. No.</sub> 20	008	04617
3	Physici	ian	1. Decedent's Name (First, Middle, Las MICHAEL A		wa DA	,		Date of Death     Month	th Day	Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give		MITIN		r Location of Death	02	12 2 4c. County	2008 y of Death	
Æ.	LAGI	lle1	BALTIMORE V.A.	MEDICAL CENTE		BALT	IMORE		N	IA	
	Funeral		5. Social Security Number 6. Security Number 11. 6. Security Number	I√⊋M 2□F	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Coul	nplace (State or Foreign untry)
	Director		Usual Residence of Decedent	50	115.			Apr.1,1			yland
ryland	how		10a. State 10b. County	10c, City	ty, Town or Loc	cation					10d. Inside City Limits
he Ma	8a-fs	ector	Maryland N/A	Ва	altimo						1 ¥Yes 2 □ No
with t	a or 2	Dir	10e. Street and Number 4813 Cordelia A	Attonito		10f. Zip Code 21 21 5		10	0g. Citizen of V	Vhat Cour	.ntry?
death	ms 23	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S	.S. 13. V	Was Decedent of His If Yes, specify Cubar		ecify Yes or No-			ican Indian,
.0036 hours after death with the Maryland	and the Medical Hydron and the many hard Medical Hydron and an attack other than "natural", or letms 23a or 28a-f show marked other than "natural", or letms 23a or 28a-f show matic event, the Medical Examiner must be notified at	b S	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Types 2 No 19 If Yes, Give	174↓	If Yes, specify Cubar	Specify:	Rican, etc.)		ck, White,	
5-C	'natur dical	Completed	15. Decedent's Edu (Specify only highest grad	ducation	16a, Decede	dent's Usual Occupa kind of work done do DO NOT use retired)	ation during most of work	rina	16b. Kind of Bu	usiness/Ir	ndustry
d 21215- filed within 72	ene. than he Mc	Jumo	Elementary/Secondary (0-12)	College (1-4or 5+)		OONOT use retired) Service		ĮV			Adminis-
	other vent, tt	Be Co	17. Father's Name (First, Middle, Last)	2 Years			18. Mother's Name				ospital
/lan	Menta arked atic ev	To B	Avon Hollman				Maxine				
Maryland 21215-0036 d 2 should be filed within 72 hours af	Is me		19a. Informant's Name/Relationship (7)		19b. Mailing	g Address (Street a	and Number or Rura	ral Route Number,	City or Town,	State, Zij	ip Code) 21215
	Health em 27 ther tr		Maxine Withersp  20a. Method of Disposition	<u> </u>		Park He	eights F	Ave Bal	timore		
Baltimore, permit. Pages 1 ar	Department of limportant: If its any injury or of once.		1  Burial 2  □ Cremation 3  □ I 4  □ Donation 5  □ Other (Specify)	97/		sition (Name of natory or other place			rowns	vill	le, Marylan
Derin Derin	Depar Impor any ir			rris	5.	240 Reis	sterstow	wn Ra B	Baltimo	Fun ore,	neral Home Md 21215
121	4	4	23a. Part1. Enter the disease, or composhock, or hear failure. List only o					or respiratory arre	st,		Approximate Interval Between Onset and Death
3	hysician /Medical		disease or condition resulting in death)	a. GASTROINT	ESTENT	AL BLEET	sing				3 DAYS
Ex	xaminer			b. CIRRHOSI	,						
Pa	Sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque							
68/60, tificate be executed	physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conseque	uence of);					11	
os/ou	/sician e buri	cal E		d	.onec . ,						
	0.00	Medical		a							
U. BOX the death cer	e atten d for u	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnan 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	ıl death 3 □E	Ectopic pregnancy Other (specify)			23d. Date Mor	te of delive onth	rery Day Year
ords, F.O	ned by e detar		Part II. Other significant conditions con		ulting in the un	derlying cause giver	ın in Part I.	23e. Did tob	acco use conti	ribute to t	the cause of death?
oquire	en sig ould br	ed b	RENAL FAILUR					1 □ Yes	s 2□No	3 ☐ Prob	bably 4 Unknown
The law	ate has be	Completed by	HEPATIC FAILL	URE				24a. Was an autopsy perform 1 Yes 2	y ned? d	Were auto prior to co death? 1 ∐ Yes	opsy findings available ompletion of cause of
	sertifics ector,	Be	25. Was case referred to medical examiner?	~ .			26. Place of Death				2,30,10
Phys.	this c	P.	1 Yes 2 No		ER/Outpatient 28b. Time of		4 LI Nursing Hon	me 5 Resider			fy)
ding C	h. : After 3 fune	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injury a Work? M 1 ☐ Ye	/ at	28d. Describe hov	v injury occurs	əd	
lor Attending Phy	ector: by the	ifica	3 Suicide 6 Could not be determined	28e. Place of injury - At hom	me, farm, stre			28f. Location (Stre		er or Run	al Route Number,
	s after al Dir	Cert	4 Enominate	building, etc. (Specify)				City or Town,	, State)		
To the Hospital or Attending Physician:	n 24 hour he Funer pletely fill	edical	one)	ysiclan: To the best of my know niner: On the basis of examination and manner stated.	vledge, death of tion and/or inve	occurred at the time estigation, in my op	e, date and place, a pinion, death occurr	and due to the car ed at the time, da	use(s) and ma	nner as s' and due t	tated. o the cause(s)
Tot	To th	M	29b. Signature and title of Centifier	2		29c. License r		29	d. Date signed	(Month,	Day, Year)
	/		1/h Com	CHIZMAR W	NO REIL	04 -119929	913735		2/12	-/20	308
	5		30. Name and address of person who co	completed cause of death (ftem 2) HIZMAR M 2 Registrar's Signature	23a) (Type, Pr	rint)	aina - C	Qn		443	2/28/
	Stat	te	7/m o Trly P. C. 31. Date filed (Month, Day, Year)	Registrar's Signati	ture	d 3. UK	Ethe Si	- DAU	more,	mis	21201
	Registra		FEB 1 9 200	8 Blown St	A 1984						

08-01169	
Brian K. Hand	

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State of Maryland / Department of Health and Mental Hygiene

nan K. Hand	State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar.  Certificate of Death Reg. No.	0461
Physician Medical Examine	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Next Decedent's Name (First, Middle,Last)	me of Death 651 hrs
A.	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death White Marsh Baltimore County	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplac	æ (State or
Director	Usual Residence of Decedent    State	MD
ow any	10a. State 10b. County 10c. City, Town or Location 10d. PA Mercer Sharon	Inside City Limits
Maryland 28a-f show d at once.	10e. Street and Number 10g. Citizen of What Country? USA	
5-0036 led within 72 hours after death with the Maryland Hygiene. I other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once Completed by Funeral Director	· · · · · · · · · · · · · · · · · · ·	ndian Black
or items	1 XNever Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.	
ours after trural", aminer	3 Widowed 4 Divorced in Yes, Give Year or Dates: 1 Yes 2 X No specify: Specify: White	
36 hin 72 ho e. than "na dical Ex	15. Decedent's Education (Specify only highest grade completed)  16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	wement
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		Velicite
212 ould be d Mental s marke ic event	Part Age 1 To Trainer, SE . Set Tree In . Newell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip	Code)
mnd 2 sho ealth and tem 27 is traumati	Jan Bartek, fiance 663 Cedar Ave. Sharon, PA. 16146  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town	1, State
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tr	1 Burial 2 Cremation 3 Removal from State West Arundel Crematory 02-16-08 Odenton, M	D
Balti permit. Departm Imports injury o	21. Signature of Funeral Service Licensus.  22. Name and Address of Facility Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD.	21227
Physician	238. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Ap	proximate Interval
/Medical Txaminer	Immediate Cause (Final disease or condition resulting in death)  a. Methadone intoxication and cocaine use  Due to (or as a consequence of):	Death
2	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
amin	Cause. Enter Underlying Cause (Disease or injury that initiated  C.  Due to (or as a consequence of):	
xecuted n and 1- transit		
760, cate be e physicia he burial	AMENDED AMENDED #23a,27,28a-f, perME,g877, 3/5/08 TT 23 Pt. 11 per ME g8/8 4/8/08 amin 23d. Date of delivery	
Ox 68760, auth certificate be exe attending physician a for use as the burial -	AMENDED #23a,27,28a-f, perME,g877, 3/5/08 TT 23 Pt. II per ME g878 4/8/08 and #23a,27,28a-f, perME,g877, 3/5/08 TT 23 Pt. II per ME g878 4/8/08 and #23a,27,28a-f, perME,g877, 3/5/08 TT 23 Pt. II per ME g878 4/8/08 and #23a,27,28a-f, perME,g877, 3/5/08 TT 23 Pt. II per ME g878 4/8/08 and #23a,27,28a-f, perME,g877, 3/5/08 TT 23 Pt. II per ME g878 4/8/08 and #23a,27,28a-f, perME,g877, 3/5/08 TT 23 Pt. II per ME g878 4/8/08 and #23a,27,28a-f, perME,g877, 3/5/08 TT 23 Pt. II per ME g878 4/8/08 and #23a,27,28a-f, perME,g877, 3/5/08 TT 23 Pt. II per ME g878 4/8/08 and #23a,27,28a-f, perME,g877, 3/5/08 TT 23 Pt. II per ME g878 4/8/08 and #23a,27,28a-f, perME,g877, 3/5/08 TT 23 Pt. II per ME g878 4/8/08 and #23a,27,28a-f, perME,g877, 3/5/08 TT 23 Pt. II per ME g878 4/8/08 and #23a,27,28a-f, perME,g877, 3/5/08 TT 23 Pt. II per ME g878 4/8/08 and #23a,27,28a-f, perME,g877, 3/5/08 TT 23 Pt. II per ME g878 4/8/08 and #23a,27,28a-f, perME,g877, 3/5/08 TT 23 Pt. II per ME g878 4/8/08 and #23a,27,28a-f, perME,g877, 3/5/08 TT 23 Pt. II per ME g878 4/8/08 and #23a,27,28a-f, perME,g877, 3/5/08 TT 23 Pt. II per ME g878 4/8/08 and #23a,27,28a-f, perME,g877, 3/5/08 TT 23 Pt. II per ME g878 4/8/08 and #23a,27,28a-f, perME,g877, 3/5/08 TT 23 Pt. II per ME g878 4/8/08 and #23a,27,28a-f, perME,g877, 3/5/08 TT 23 Pt. II per ME g878 4/8/08 and #23a,27,28a-f, perME,g877, 3/5/08 TT 23 Pt. II per ME g878 4/8/08 and #23a,27,28a-f, perME,g877, 3/5/08 TT 23 Pt. II per ME g878 4/8/08 and #23a,27,28a-f, perME,g877, 3/5/08 TT 23 Pt. II per ME g878 4/8/08 and #23a,27,28a-f, perME,g877, 3/5/08 TT 23 Pt. II per ME g878 4/8/08 and #23a,27,28a-f, perME,g877, 3/5/08 TT 23 Pt. II per ME g878 4/8/08 and #23a,27,28a-f, perME,g877, 3/5/08 TT 23 Pt. II per ME g878 4/8/08 and #23a,27,28a-f, perME,g877, 3/5/08 TT 23 Pt. II per ME g878 4/8/08 and #23a,27,28a-f, perME,g877, 3/5/08 TT 23 Pt. II per ME g878 4/8/08 and #23a,27,28a-f, perME,g877, 3/5/08 TT 23 Pt. II per ME g878 4/8/08 and #23a,27,28a-f, perME,g877, 3/5/08 TT 23 Pt. II per ME g878 4/8/08 and #23a,27,	Year
that the deatl ted by the att detached for by Physical By Physical		ause of death?
S, P.( puires that an signed lid be deti	Cardiomegaly  1 Yes 2 No 3 Probably	
e law rec e has bee ge 2 shou	performed? death?	etion of cause of
tal Rection: The certificate ector, page	25. Was case referred to medical 26.Place of Death (Check only one)	2 No
of Viting Physic After this current direction on To E	1 No line of Injury 1286 Date of Injury 1286 D	ne
sion (tending death. At the fur sation	1 Natural   5 Pending   Pending   Nestigation   Fnd 2/10/2008   Fnd 6:45 am   1 Yes 2 X No   Unk	
Division At Spital or At Jours after diversal Direct filled in by Certifica	1 Natural 2 Accident 3 Suicide 4 Homicide 4 Homicide 2 See. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) other scene 17 Morning Ct. BAltimore,	
To t vith com	Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Description)	
	O.C.M.E. February 10, 2008	
07	30. Name and address of person who completed cause of death (Item 23a).  Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registra	ate 31. Date filed (Month, Day, Year) 22. Registrar's Signature	

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Hilliard Mattie 2008 5:25 a /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore Joseph Richey If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2√2 F 246-30-4881A 10-19-1927 N.C. Director 80 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 1 √Yes 2 No Director N/A MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21231 U S 100 N. Broadway Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Days Inn Housekeeping
18. Mother's Name (First, Middle, Maiden Surname) 12th grade 17. Father's Name (First, Middle, Last) Maryland Be ( and Mental I pe. 1 and 2 should b Health and Menta William Westry Mattie Joyner ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Balto, MD 21213 3781 Ravenwood Avenue mportant: If Item 27 Mary E. Harris-Sister timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages, 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 Removal from State 2-21-2008 Rocky Mt, N.C. Baker's Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East 21202 la North Avenue Balto, 1101 E. Approximate Interval Between Onse and Death 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each ing. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Ö 9 Unknown ئے 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy 21000 Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 No 1 Yes 3□ DOA 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Mapner of Death 28b. Time of 28c. Injury at Work? Division Hospital or Attending 1 🛮 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Thomicide To the Funeral Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) cause of death (Ite

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

			For	State of Maryland	•		nd Ment		1	008	04620
			State Registrar		Certifica	ite of Death	0.5		g. No.		3. Time of Death
r	Physicia		Decedent's Name (First, Middle, Last)	1			M	ate of Death onth	Day	Year	1 0 00
14	/Medic	al	Duane Howa	50	1			EB_	10	2008	
4	Examin	er	4a. Facility Name (If not institution, give s	treet and number)	45. CII	y, Town, or Location of			40. 0001	ity of Beatif	NIA
			Union Memorial  5. Social Security Number 6. Sex	7. Age (In yrs. la	st hirthday) If Und	Baltime der 1 Year   If Under 24	1 Hrs 8 D	ate of Birth		9. Birthi	place (State or Foreign
	Funeral		. 136	M 2 F	Yrs. Month		Min. (A	fonth, Day,	138	Coui	ntry) MD
	Director	-	219-34-70-71 Usual Residence of Decedent	6			100	3110	,		
	land ow		10a. State 10b. County	10c. City	Town or Location						10d. Inside City Limits
	Many -f sh	ţċ	PA	L;+	Heston	12					1 ☑Yes 2 ☐ No
	r 28a	Director	10e. Street and Number		10f. 2	Zip Code		10	g. Citizen	of What Cou	ntry?
	h wit	a	360 Misherry	wood Drive	e 1	7340				USA	
	deat	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	6. 13. Was De	cedent of Hispanic Origi pecify Cuban, Mexican,	in? (Specify \ Puerto Ricar	res or No- n, etc.)		Race - Ameri Black, White,	
စ္	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medion Examiner must be notified at	F	1 Never Married 2 Married	1 ∐ Yes 2 ∰HNo If Yes, Give		2MNo Specify:			Spe	cify: w	ni te
21215-0036	ural",	d by	3 Widowed 4 Divorced	Year or Dates:	10- Dd#-11	avel Occupation				f Business/Ir	
5-0	72 h "natu	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Decedent's U (Give kind of	work done during most ( use retired)	of working		TOD. KING O	Daginega/ii	ladony
121	within sne.	du	Elementary/Secondary (0-12)	College (1-4or 5+)	Mainte				Mir	tena	nce
	Hygid Hygid ther int, th		17. Father's Name (First, Middle, Last)		- Chile		's Name (Firs				
an(	d be	Be c	Boland	Howard		Mo	rtho	Re	ter	son	
Maryland	12 should be filed within hand Mental Hyglene. 7 Is marked other than "traumatic event, the Mec	ဥ	19a. Informant's Name/Relationship (Ty)	11000	19b. Mailing Addre	ess (Street and Number			City or To	wn, State, Zi	p Code)
$\mathbf{z}$	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natu any Injury or other traumatic event, the Medical once.		Janice Howard	Lwife	3600 M	ic Sherry su	, pood	Dr. li	Hles-	taun,	PA 17340
တ်	s 1 and 2 f Health tem 27 l		20a. Method of Disposition	20b. Pl	lace of Disposition (femetery, crematory)	Vame of or other place)	Date			on - City or 1	
altimore,	ages ent of nt: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		etro Cre		2-21-	08	Bal	timor	e)mD
Ħ	permit. Pag Department Important: I any Injury c		21. Signature of Funeral Service Licens		22. Name	and Address of Facility	,	-			
Ba	permit. Departr Imports any Inj		1 / June	1 Larch	エエ	AM 1232	Midv	alle	Dr.	Jess	P, PA 18434
			23a. Part1. Epter the disease, or compleshock of heart failure. List only of	ications that caused the death	. Do not enter the n	node of dying, such as o	cardiac or res	piratory are	est,		Approximate Interval Between
	Physician		Immediate Cause (Final			FARCTI					Onset and Death  24 Hours
	/Medical		disease or condition resulting in death)	Due to (or as a consequ		THE THE	2.4				
8	Examiner										
ı,		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):						
	cuted nd ransit	Examiner	that initiated events	o							
Ó	be execut iclan and burial-trar	Ë	resulting in death) Last	Due to (or as a consequ	uence of):						
8760	icate be executed physician and s the burial-transit	dical		d							
9	ertific ing pl	Mec	IF FEMALE:						004	D-46 del <sup>5</sup>	
Вох	ath ce trendi	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregna 1☐Live birth 2☐Feta	1 death 3 □Ectopi	c pregnancy			230	Date of deli Month	Day Year
	requires that the death certifit een signed by the attending p nould be detached for use as	Completed by Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	eath 5□Other	(specify)					
P.0	d by letach	Phy	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the underlying	ng cause given in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
	w requires that been signed b should be deta	þ	ratti. Other significant sentimens so	Time and a second secon	,	, ,		1 🗆 Y	es 2 N	lo 3□Pr	obably 4 Unknown
oro		ted						24a. Was a	n s	Ab Were au	tonsy findings available
ec		ngu						autops perfor	sy med2	death?	topsy findings available completion of cause of
F	40 57	S						1□ Yes	2 <b>Y</b> No	1 □ Yes	2 No
Vita	Physician: The la this certificate har ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:		Othor	of Death (Ci			Tou (0)	
or	this ald	10	1 ☐ Yes 2 ☑ No  27. Manner of Death	1 Inpatient 2	28b. Time of	DOA 4LINU	rsing Home 28d.	Describe h			спу)
L C	ding F h. After funera	ion	1 ☑Natural 5 ☐ Pending	(Month, Day Year)	Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ I					
Sign	Attending r death. ector: After by the funer	icat	3 Suicide 6 Could not be	28e. Place of injury - At he building, etc. (Specif	ome, farm, street, fac	ctory, office	28f.	Location (S	treet and N	lumber or Ri	ural Route Number,
Division or Vital Records,	or A after Direct in by	ertif	4 ☐ Homicide determined	building, etc. (Specif	(y)			City or Tow	n, State)		
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification:	29a. Certifier 1 Certifying Phy	sician: To the best of my kno	wledge, death occur	rred at the time, date an	id place, and	due to the	ause(s) ar	d manner as	s stated.
	e Hoo 24 h e Fur letely	dic	(Check only 2 ☐ Medical Exam one)	iner: On the basis of examina and manner stated.	ation and/or investiga	ation, in my opinion, dea	ath occurred	at the time, o	date and pi	ace, and due	e to the cause(s)
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier		:	29c. License number		2	29d. Date s	igned (Mont	th, Day, Year)
			> Jung	, M.D.		AT 2439	8946		FER	510,	2008
	1		30. Name and address of person who o	ompleted cause of death (Iten	n 23a) (Type, Print)						
0	5			OOR, M.D.		NEMORIAL	L Ho	SPITI	AL,	mo	
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa		19	-				
	Regist	rar	FFR 1 9 2	008 Mariner	A ASSA	E.					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year **Physician** LaVonne Katherine Hemphill February 15,2008 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE MEDICAL CENTER TOWSON BALTIMORE Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplace (State of I. Country)
April 25,1926 Toledo, Ohio Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdav 6. Sex **Funeral** 1□M 2≱F Min. 81 Hours 300-20-8492 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Director Maryland Baltimore County Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or Items 23a or 3 6451 N. Charles Street 21212 United States by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Physical Education Teacher High School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kenneth Gordon Smith Elizabeth Borchardt 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1672 Beekman Place N.W. Mr. Hunter S. Hemphill (Son) Washington, D.C. 20009 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel | Feb.18,2008 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Peaceful Alternatives Funeral&Cremation Ctr.,P. 2325 York Road Timonium, Maryland 21093 01 e, or complications that caused the death. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) days INTA CrAnial **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dunito for as a consecuence of Examine Due to (or as a consequence of): The law requires that the death certificate be exer Division or Vital Records, P.O. Box 68760, Physician/Medical attending properties for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No ate has l autopsy 2 No 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aft

To the Funeral DI

completely filled in 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number February 16, 2008 N. Chniles St. address of person who completed cause of death (Item 23a) (Type, Print) Balto Md ZIZOX h 6701 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State 7 2008 Registrar

08-01134 Welborn Higgs

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

born Higgs		1- For State	ate of Maryl		rtment of tificate of		Mental		2 ( Reg. No.	008 04622
Physicia		Registrar 1. Decedent's Name (First, Midd	le,Last)				<del></del> -	2. Date of Dea	ath Dav Year	3. Time of Death
dical Exami	ner	Welborn Higgs  4a. Facility Name (if not institution			- 1.	O:h . T I		February	8, 2008 4c. County of	2242 hrs
		Route 27 and Waters		umber)	] 4	b. City, Town, or L Mount Airy	ocation of De	eatn	Carroll	Death
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of B		9. Birthplace (State or
Director		401-32-8738	1 X M 2 F	7	8 Yrs.	Months Days	Hours	Min. 02/1	4/1929	Foreign Country) <b>KY</b>
		Usual Residence of Decedent								
v any		10a. State 10b. County		10c. City,	Town or Location	on				10d. Inside City Limits
and Show	or	MD Carr	oll	Mt	. Airy					1 Yes 2 X No
Mary r 28a- ed at c	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	at Country?
15-0036 filed within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once.		6700 Runkles				21771			USA	Dist.
ith will tems	Funeral	<ul><li>11. Marital Status</li><li>1 Never Married 2 X N</li></ul>		ecedent Ever in U. Forces?		Decedent of Hisp es, specify Cuban,		( Specify Yes or Nerto Rican, etc.)	lo- 14. Race - White,	American Indian, Black, etc.
ter dez ', or i			vorced If Yes, Give Yes	2 No Par <b>1 9 5 8 – 6 /</b> 1	1	Yes 2 X No	specify:		Specify:	White
hours afte "natural", Examiner	d by	15. Decedent's Education (Spe			16a. Decedent	's Usual Occupation	on (Give kind		16b. Kind of Bus	
72 ho n "na al Ex	Completed	Elementary/Secondary (0-12)	College	(1-4 or 5+)	during mo	st of working life.	DO NOT use	retired)		
5-0036 led within 72 Hygiene. other than '	Пр			4	Elec	tronics				itomation Svc.
5-0 iled w Hygic I othe		17. Father's Name (First, Middle				1		•	, Maiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	) Be	Morgan Hig  19a. Informant's Name/Relation			10h Mailina	Address (Street		Marie W	elborn umber, City or Town	State Zin Code)
MD 21 nd 2 should alth and Me m 27 is ma	٦	Mary Elizabet		ri fe	F 27				MD 21771	10.
- P# E #		20a. Method of Disposition	11 111995/ #	20b. I	Place of Disposi	tion (Name of cem		Date		City or Town, State
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Den Den Inju		Han 1	2 Cew	re						d, MD 21784
Physician		23a. Part I. Enter the disease, o	r complications that	caused the death	. Do not enter th	e mode of dying, s	such as cardi	ac or respiratory a	rrest, shock, or hea	rt Approximate Interval Between Onset and
/Medical ~xaminer		Immediate Cause (Final diseas	B. A. (14) and a single	ijuries						Death
<b>Xannines</b>		or condition resulting in death)	Due to (or as	a consequence o	ıf):					
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ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed redath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transit		UNPENDED		<del></del>				····		
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Sox 68761 leath certificate e attending phy for use as the b	Physician/IV	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the Total	, outcome of preg birth		al death 3	Ectopic pre	egnancy	Month	Day Year
Box 6 e death cer the attendi ed for use	Sicia		oknown	gnant at time of de	eath 5 Ott	ner (Specify)				1
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ires that the d signed by the	by	r art ii. Other significant cond	tions contributing	to death but not i	esolulig iti tile o	ndenying cause gi	verriir are i.			Probably 4 Unknown
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n of Vi ding Physi After this funeral dii	[ 은	1 Yes 2 No 27, Manner of Death	28a, Dat	e of Injury	28b. Time of it	0	y at Work?		e how injury occurre	
nding nding th.	<u>.</u> .		nding Feb 8,	nth Day, Year) 2008	2234 hrs	1 Y	es 2 🗸 No	Driver auto	o auto collision	
Division tal or Attendir rs after death. al Director: A led in by the fu	icat		estigation 28e. Pla	ace of Injury - At h	ome, farm, stree	et, factory, office but	uilding, etc.			er or Rural Route Number, City
Divi Hospital or 24 hours afte Funeral Dir tely filled in	Certification:	Outdoo	uld not be ermined (Specific	Major Roa	d / Highway			or Town Route 27 ar	, State) nd Watersville Ro	ad, Mount Airy, MD
Hosp 24 hou Fune tely fi		29a. Certifier 1 Certifying I	hysician: To the b	est of my knowled	lge, death occur	red at the time, da	te and place,	and due to the ca	use(s) and manner	as stated.
To the Ho within 24 h To the Fur	Medical	one) 2 Medical Ex	aminer: On the basis	s of examination a stated.	and/or investigat	ion, in my opinion,	death occurr	red at the time, da	te and place, and d	ue to the cause(s)
F 8 F 8	₩.	29b. Signature and title of certif				29c. License				ed (Month, Day, Year)
_		Monyone, 1	helfred	l		O.C.N	И.E.		February 9	, 2008
		30. Name and address of person		,		C:	. It's me	4D 04004		
0+1		Margarita Korell MD.		edical Examir		enn Street, Ba	aitimore, N	עוט 21201 		
_	tate	31. Date filed (Month, Day, Year FEB 1 9	2008	Registrar's Signat	ure	el .				

08-01176 Blanche Harris- Hi	cks		i <b>se Type</b> State	or Print in B of Maryland	l <mark>ack In</mark> d	d <b>elib</b> rtme	ole Ink. Eint of Healt	n <mark>sure All Co</mark> th and Menta	opies Are Leç al Hygiene		08 0462
		- For State tegistrar			Cen	ifica	te of Deati	h	Re	eg. No.	
Physician Medical Examine	/ er,	1. Decedent's Name (	not institution, gi	r.ane  I.ane ive street and number	lle		Harris 4b. City, T	own, or Location of	2. Date of Deat Month February	h Day Year 10, 2008 4c. County of De	3. Time of Death 1136 hrs
`		5. Social Security Nu		Sev 7 A	ge (In yrs. la	st hirthe		er 1 Year   If Under	24Hrs. 8. Date of Bir	th(MM/DD/YYYY) 9.	Birthplace (State or
Funeral Director	L	239-48-6	791 1	M 2X F	74	3.011.11	Yrs. Month		Min.		reign Country) NC
ń	-	Usual Residence of D 10a. State	Ob. County		10c. City,	Town o	r Location				10d. Inside City Limits
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other transmette event, the Medical Examiner must be notified at once.		MD	NA			Bal	timore				1 X Yes 2 No
arylan	Director	10e. Street and Numb	ber				10f. Zip	Code	1	0g. Citizen of What (	Country?
the Man or 2	5	4019 Duv	all Av	re				21216		U.S.	A •
with ms 23	ᇎ	11. Marital Status		12. Was Deceder		S.	13. Was Decede	ent of Hispanic Origi fy Cuban, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)	- 14. Race - Al White, et	merican Indian, Black, c.
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36 nin 72 e. than '	<u>e</u>	12th gra		2yrs	0.,	P	arent	Liaison		Public	Schools
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215 se file mtal H; ked o	8	Roger Jo	hnson					Lill	ian Wood ber or Rural Route Nu		
ould d Mer is mar	] د	19a. Informant's Nam	ne/Relationship								State, Zip Code) 21216
MD d 2 sh lith an m 27 i				-Daughter			Disposition (Na		, Baltimo	20c. Location - Cit	
ore tr		20a. Method of Dispo		Removal from S	State	cremato	ry or other place	+)			
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The state of the s	-			b.		,					
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Box 68760, e death certificate be except the attending physician ed for use as the burial	sician/Medical	IF FEMALE:		23c. If yes, outc	ome of preg	nancy				23d. Date of de	
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Sox death of atternation for up.	S.	1 Yes 2 🗸 N	io 9 Unkno			5	Other (Sp				
n of Vital Records, P.O. Box 687 ing Physician: The law requires that the death certificate that been signed by the attending funeral director, page 2 should be detached for use as	Phy	Part II. Other signif	icant condition	s contributing to de	ath but not r	esulting	in the underlyin	g cause given in Pa			ite to the cause of death?
P.O.	Completed by	Chronic Alc	oholism			_					Probably 4 V Unknown
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/ita	o Be	examiner?	2 No	Hospital: 1 Inpa	tient 2	ER/O	utpatient 3	DOA Other	Nursing Home 5	Residence 6	
of \rightarrow Ph; therefore the present t	<b>⊢</b>	27. Manner of Death		28a. Date of I	njury v.Year)	28b.	Time of Injury	28c. Injury at Work		how injury occurred	I
On rendin rath.	뎙	1 Natural 2 Accident	5 Pending Investig	g				1Yes 2			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification:	3 Suicide	6 Could n	28e. Place of	Injury - At h	ome, fa	rm, street, facto	ry, office building, et	28f. Location or Town,		or Rural Route Number, City
Di Ours a Peral I	Ę.	4 Homicide	determi	(-)							
e Hos n 24 h e Fun letely		29a. Certifier (Check only one)	Certifying Phys	sician: To the best of	my knowled	lge, dea	ath occurred at the	ne time, date and pla ny opinion, death oc	ace, and due to the cal courred at the time, dat	use(s) and manner a e and place, and due	s stated. e to the cause(s)
To th withii To th	Medical			and manner state	ed.			9c. License number			(Month, Day, Year)
	Σ	29b. Signature and	title of certifier					O.C.M.E.		February 11	
~		/ X a	- Cerl	evil)	f dansk (t)	2021					
6	(	30. Name and address  Laron Locke		no completed cause c sistant Medical E		n 23 <b>a</b> ) <b>11</b> 1	1 Penn Stree	et, Baltimore, M	ID 21201		
Sta	ıto.				trar's Signat		- A	-1			· · · · · · · · · · · · · · · · · · ·
Registr			FFR I	9 2008 1	Carren a	Sir	A 384	<u> </u>			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 7:201M E EBR44 RY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 30 N 18 BALTIMORE COURS If Under 24 Hrs. If Under 1 Year 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 🛠 🗆 F Director 86 240-28-6357 NC Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health end Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Baltimore Director MD NA 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21216 2725 Walbrook Ave Apt 616 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black Specify. ģ Specify: XXWidowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Security Adm Clerk 12th grade na permit. Pages 1 and 2 should be filed v Department of Health end Mental Hygie Important: If item 27 is marked other: any In]ury or other traumatic event, <u>tt</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jane Hodges George Elliot 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 19a. Informant's Name/Relationship (Type. Print) 4805 West Forest Park Ave, Baltimore, Edmonia Yates-Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial 2/18/08 Arbutus, Md 21. Signature of Funeral Service Licen 22. Name and Address of Facility
March F/H West Thompson 4300 Wabash Ave, Baltimore, Md 21215 1 me 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shirts, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** V0C /Medical Du to (or as a consequence of): RTENSIVE **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last we to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the buriel-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 □ No 1 ☐ Yes 3 Probably 4 D⊌nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an page 2 1∏ Yes 2 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA P 1 hpatient 2 ER/Outpatient 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

Division or Vital Records, P.O. Box 68760

State Registrar 29b. Signature and title of oertifier

31. Date filed (Month, Day, Year)

1

32. Régistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. Lîcense number

BON SECQUES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-01300 State of Maryland / Department of Health and Mental Hygiene Gilmore Howard 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 15, 2008 0055 hrs Howard Medical Examiner Kearney Gilmore 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Maryland General Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Country) NC MD Months Director 25 05 1 X M 2 Yrs 216-16-0845 Usual Residence of Decedent 10d. Inside City Limits any 10b. County 10c. City, Town or Location 1 X Yes 2 No or 28a-f show Baltimore NA MD hours after death with the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number U.S.A. 21216 2013 Wheeler Ave 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X X Married Black Specify: Yes 2 X No specify: Divorced Giv 7=7-43-3-10-46 "natural" ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Army Corp of 15. Decedent's Education (Specify only highest grade completed) Completed Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natinjury or other traumatic event, the Medical Examinjury events are supplied to the page 1 and 1 a Elementary/Secondary (0-12) College (1-4 or 5+) Surveyor Engineers 3yrs 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Alston Be Thomas Howard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2013 Wheeler Ave, Baltimore, Md 21216 Novene Howard-Wife 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State 2/19/08 Baltimore, Inc Metro Crematory Donation 5 Other Specify: 22, Name and Address of Facility 21. Signature of Funeral Service License March F/H West 4300 Wabash Ave Baltimore, Md Approximate Interval Between Onset and hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part I. Enter the disease, or complications Physician failure. List only one cause on each line. /Medical Death a. Atherosclerotic Cardiovascular Disease mmediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cauce (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Eliospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Physician/Medical 12 per fh UNPENDED X #FNDED peFH, g877, 3/5/08 TT signed by the attending physician be detached for use as the burial Division of Vital Records, P.O. Box 68760, 3d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknowr 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed ficate has been si 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? this certificate has performed? 2 No Yes 2 V No 26.Place of Death (Check only one) 25. Was case referred to medica Be examiner? Other; Hospital: Nursing Home 5 Residence 6 Other Inpatient 2 FR/Outpatient 3 No 1 🗸 Yes 2 After t' 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 V Natural 1 Yes 2 No Pending d in by the f 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) determined Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I within 2 To the I and manner stated 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 15, 2008 O.C.M.E. 30. Name and address of person who completed cause of doubt (Item 23a) 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 17.18 per inf 9876 2-19-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Vear 08 0641 M **Physician** ANCOCK RA NCES 02 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 8509 Keebler Drive Clinton Prince George's If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 € Yrs 93 Jan 29. 1915 Maryland 577 36 5178 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examingr must be notified at once. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director Maryland Prince George's Clinton 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code United States 8509 Keebler Drive 20735 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 □ Yes 2 □ No If Yes, Give X X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2☐ No 3altimore, Maryland 21215-0036 Specify Specify: Be Completed by White 3√Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Statistician DC Government 12 17. Father's Name (First, Middle, Last)
Samuel Hancock 18. Mother's Name (First Hiddle, Meider Surname) Henderson ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William Hancock (Grandson) 8509 Keebler Drive, Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 2/20/2008 Brentwood, Marylan

22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Funeral Service Licensee Tous That Alexandria Ferry Road, Clinton, MD 20735 M60257 Approximate Interval Between Onset and Death 1 shift. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) year Physician /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusity (or as a consequence of) Physician/Medical Examiner the burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the burla IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon 1 Yes 2 No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ð 3 Probably 4 □Unknown UOW 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1☐ Yes 2☐No certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ို 1 🔲 Inpatient After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending וס ו ס ויסיי. within 24 hours after ייטי. To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

10

Registrar DHMH 17 Rev 1/2001

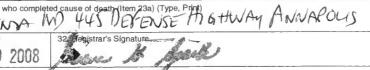
State

Year. 2008

29b. Signature and title of certified

Name and address of person

31. Date filed (Month, Day,



29c License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 30 AM Year Physician FEBRUARY OG, 2008 TLANKLIN JOHN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE BALTIMORE REHABILITATION EXTENDED CARE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Dec 13, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Maryland 1X M 2□ F 76 1931 216-28-7396 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1XTYes 2 □ No Director Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21224 USA 3416 Mt. Pleasant Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No white Specify: þ 3 ☐ Widowed 4 ☐ Divorced 'natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 7 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 truck driver transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be Louis Hartman 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joann Hartman/spouse 3416 Mt. Plesant Avenue Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 Department of Important: If it any Injury or c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ronald S 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street licensee #ector ins Paltimore, MD 21201

23a. Part1. Inter the disease, or o'mplicatin's that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, cheart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) OBSTRUCTIVE PULMUNARY DISEASE CHRONIC **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown HEA Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 s CHRONIC autopsy perform 2 No 1 TYes 2 100 director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural n 24 hours after death.
ne Funeral Director: A
pletely filled in by the ft. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

THOMAS S. MILLER

FFB

men

9 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3900 LOCH

Registrar's Signature

29c. License number

30272

RAVEN BOULEVARD BALTIMORE MD 21218

29d. Date signed (Month. Day, Year)

December 1 March (1905)   Ministry   Minis			•	For State Registrar	State of Mary		epartment of H Certificate of L			eg. No. 2008	3 04629
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Second of the company of the compa		Funeral		Social Security Number     6. S	Sex 7. Age (In	n yrs. last birth	day) If Under 1 Year	If Under 24 Hrs	8. Date of Birth (Month, Day,	l o Bir	rthplace (State or Foreign
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Physician // Medical Examiner  Saminer	ľ	<b>₩</b>		23a. Part1. Enter the disease, or come shock, or heart failure. List only	plications that caused the	e death. Do no	at enter the mode of dyir	ng, such as cardiac o	or respiratory arr	rest,	Approximate Interval Between
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The standard of the standard o		7-80 JBs	F.	Sequentially list conditions, if any, leading to immediate	b. CUTAN. Due to (or as a co	onsequence of	-CELL LY	mphomp			7 MON MA
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FERMALE: 23b. Was adecedent pregnant in the past 12 months?   23c. If yes, outcome pf pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnancy   Month Day Year   1   Year 2   Month Day Year   1   Live birth 2   Fetal death   3   Ectopic pregnancy   Month Day Year   1   Year 2   Year   1   Year 2   Year   1   Year 2   Year   1   Year 2   Year   1   Year 2   Year   1   Year 2   Year   1   Year 2   Year   1   Year 2   Year   1   Year 2   Year   1   Year 2   Year   1   Year 2   Year   1   Year 2   Year   1   Year 2   Year   1   Year	Ž	an an		resulting in death) Last	Due to (or as a co	onsequence of	):				
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Registrar FEB 1 9 2008		Sta	te		32. Rapistrar's	Signature			si n'n [	TEV DIUM	
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DHMH 17 Rev 1/2001

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 9, Richard W. Hynson, Jr. February /Medical 2008 10:40 A M 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Montgomery Rockville Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Days Months 1**X** M 2 □ F Hours Min. 579-30-1717 Director 81 April 29, 1926 Washington, D.C. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits must be notified at Director Maryland 1 XYes 2 ☐ No Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or it ury or other traumatic event, the Medical Examiner must be not or other traumatic event, the Medical Examiner must be not or other traumatic event. 415 Russell Avenue, #106 20877 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? WWII 1 M Yes 2 □ No WWII If Yes, Give Year or Dates: Korean 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No ģ Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Life Insurance Salesman Life Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard W. Hynson, Sr. Ethel Weller 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen H. Vettori / Daughter 11 Vashi Lane, Rockville, Maryland 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot February 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 14, 2008 Bethesda, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funefal Service Licensee 22. Name and Address of Facility.
Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 Robert A. Pumphrey Funeral Home / Ro 300 West Montgomery Avenue, Rockvil 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, we heart failure. List only one cause on each line. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Lung Cancer Months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed and burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death Day 5 ☐ Other (specify) 1□Yes 2□No ed by the detached 9 Unknown 9 Unknown ate has been signed page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 12 No 2∐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 1 X Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) after death. 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 X Natural Iniury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ö Hospital To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D62234 February 12, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manish Agrawal, MD 9707 Medical Center Drive, #30, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

FEB

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: /
completely filled in by the f Hospital To the

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2/>/ BRECKER mn DomE 32. Registrar's Signature

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29c. License number

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29d. Date signed (Month, Day, Year)

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			1 - For State Registrar	State of	Marylan		artmen rtificate			and M		giene 2 Reg. No.	008	04	632	
	Physic		1. Decedent's Name (First, Middle,  Annette Hall	Last)							2. Date of De Month	Day	Year 2008	3. Time of		
	/Medi Exami		4a. Facility Name (If not institution, s Futurecare – Lo			4b. City,		Location o		02	4c. County of Death			- P		
- 74.4	Funeral Director		5. Social Security Number 212–42–3949  Usual Residence of Decedent	.Sex 7. 1 □ M 2 🙀 F	Age (In yrs. 63	last birthday) Yrs.	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birl (Month, Da July 17	h y, Year) <b>1944</b>	9. Birth	intry) MD	or Foreign	
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	th with the 23a or 28 ist be not	Funeral Director	10e. Street and Number 3207 Brighton Stre	eet			10f. Zip		1216			10g. Citizen	of What Cou	intry?		
Baltimore, Maryland 21215-0036	172 hours after death with the Maryland "natural", or items 23a or 28a-f show school Examiner must be notified at		11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	Armed Force	1 ☐ Yes 2 <b>XX</b> No If Yes, Give			ent of His	spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		Black, White	merican Indian, Inite, etc. Black		
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P.O. Box 68	death certifi e attending ; d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1											-	Year	
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ion or	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigati	28a. Date of I (Month, I		28b. Time of Injury		Bc. Injury Work		2	8d. Describe h			iy)		
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,	2		30. Name and address of person wh	o completed cause o	f death (Item	-	Print)			ITE !	203 /	BALTO	MA	دولتي	79	
	Sta Registr		31. Date filed (Month, Day, Year)		strar's Signal	ture	land !	,		, -				27-1		

DHMH 17 Rev 1/2001

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			For State Registrar	State of Ma	iryland	•		Health and N f Death		ene. U U g. No.	0	04000				
À.	Dhyoisi	an .	1. Decedent's Name (First, Middle, L	_					2. Date of Death		Year	3. Time of Death				
	Physici /Medic			E ISETT					LER	16 20		4:15-AM				
	Examin		4a. Facility Name (If not institution, g				Ib. City, Town	, or Location of Death		4c. County o		UNDEL				
	E		MORNINGSIDE HOUSE  5. Social Security Number  6.		(In yrs. las	t birthday)	If Under 1 Ye	ar If Under 24 Hrs.	8. Date of Birth			lace (State or Foreign				
	Funeral Director		214 20 9325	1□M 2 <b>V</b> F	81	Yrs.	Months Day	rs Hours Min.	(Month, Day,	-1926	MAR	LAND				
	yland 10w		Usual Residence of Decedent  10a. State 10b. County			Town or Locat					1	Od. Inside City Limits				
	a-f st	ctor	MD ANNE A	カスとひかト	HA	2074	R					1 ☐ Yes 2 No				
	death with the Maryland me 23e or 28e-f show roust be natified at	Dire	10e. Street and Number 75 48 OLD T	ELEGRAPH	Roah	\$me	10f. Zip Cod	4	10	og. Citizen of WI		itry?				
	ns 23	era	11. Marital Status	12. Was Decedent		1		of Hispanic Origin? (Si uban, Mexican, Puerto	pecify Yes or No-	14. Race	- Americ	an Indian,				
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28a-f show item 27 is marked other than "natural", or items 23e or 28a-f show other treumatic event, the Madical Examinar mast he mailised at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces?  1 ☐ Yes 2 ☑ 1  If Yes, Give Year or Dates:	lo		Yes 2501		Hican, etc.)		, White,	etc.				
2-0	72 ho	sted	15. Decedent's (Specify only highest of	Education grade completed)		16a. Deceden	d of work do	ne during most of wor	king	6b. Kind of Bus	iness/In	dustry				
121	Man "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO	NOT use re	ired)		NA						
2	filed v Hygie other t		17. Father's Name (First, Middle, La	st)		11003		18. Mother's Nam	ne (First, Middle, N	faiden Surname	)					
Maryland	lid be ked o	To Be	Day of Day of Share													
ary	2 should be and Mental Is marked of eumatic even		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip													
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Baltimore,	Pages 1 ment of H ant: if ite ury or otl		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Onation 5  Other (Specific Property of the Control Property of the Co		cem	DHY GUT	tory or other	olace)	8/2008		•					
Balt	permit. Pages Department of Important: If it eny injury or o		21. Signature of Funeral Service Lic	ensee				dress of Facility	1533 CONNE	TEY DIS H	ומאה	Grove aminy				
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	or respiratory arre	est,		Approximate Interval Between									
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		/Mec	IF FEMALE: 23b. Was decaded as a control of pregnancy 23d. Date of delivery													
Box	death certi e attending id for use a	by Physician/M	23b. Was decedent pregnant in the past 12 gronths? 1 □ Yes 2 No	1 ☐Live birth 4 ☐Pregnant at	2 Fetal de	eath 3 E	ctopic pregna Other (s <i>pecif</i> y			Mon		Day Year				
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_	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	ledical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis o and manner st	examinatio	ledge, death o	occurred at the stigation, in r	e time, date and place ny opinion, death occu	and due to the carred at the time, d	ause(s) and mar ate and place, a	nner as s	stated. o the cause(s)				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year SERGUET TOFFE 1:05 PM 2002 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 3 AMLEHT COURT, APT. BALTIMORE BALTIMORE If Under 1 Year | if Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign **Funeral** Country UKRAINE Months Days Hours Min (Month Pay 19922 1 ☐HM 2 ☐ F 220-35-3198 85 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 AMLEHT COURT, APT. 1-D 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 ☐ Yes 2 🛣 No WHITE Specify Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION ENGINEER CONSTRUCTION permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important; If item 27 is marked other i any injury or other traumatic event, tt 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHAIM IOFFE BASCHA MUSINA ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TCHARNA PESOCHINA / WIFE 3 AMLEHT COURT, APT. 1-D, BALTIMORE, MD 20b. Place of Disposition (Name of Carnety Committee of Child Like ARLINGTON) or other place UK AMUNO CONG. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 □ Removal from State 4 Donation 5∕☐ Other (Specify) 02/15/2008 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final BRANN **Physician** CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Yes 2 100 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician Division or Vital Records, P.O. Box 68760 this n 24 hour-the Funeral Dire within 2 To the

be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Registrar

State

29a. Certifier

29b. Signature and title of certifier

BARATUNDE

31. Date filed (Month, Day, Year)

FEB 19

Medical

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIVING TE HEREW

mi

32. Registrar's Signature

Carried Sal

PHASICIAN

2008

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

130064533

2434 W. BELVEDERE

29d. Date signed (Month, Day, Year)

BATTMOREIMI

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19b per fh 8876 2-19-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year FEBRUARY PAGE JOHNSON 11 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PALTIMORE CITY
If Under 1 Year | If Under 24 Hrs JOHNS HOPKINS MIOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. 216-36-027 Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at show 1 LYYes 2 □ No Director timor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Was Decedent Ever in U.S. Armed Forces? Funeral 7 Is marked other than "natural", or items traumatic event, the Medical Examiner me Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2□No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by 3 Widowed 4 Divorced Blac 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene Important: If Item 27 Is marked other than any Injury or other traumatic event, the Misonce. Elementary/Secondary (0-12) 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٥ ohnson 19a. Informant's Name/Relationship (Type. Print) (51 Ster) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9704 VIS, KO m 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee LiRus Home 21216 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS 8 DAYS /Medical Due to (or as a consequence of): Examiner 6 DAYS Sequentially list conditions, and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ASCENDING CHOLANGITIS Examiner Due to for as a consequence of law requires that the death certificate be executed BILE DUCT OBSTRUCTION FROM burial-tran Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the as ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by cate has been signated bage 2 should b 1 ☐ Yes 2XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy certificate performed funeral director, 25. Was case referred to medical Be 26. Place of Death Check onl one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ပ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier EcrtifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MEDICAL DOCTOR RES-000 FEBRUARY um talque 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21287 LAEGER JOHNS HOPKINS HOSPITAL 600 NORTH WOLFE STREET, BALTMORE, MIRYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 9 2008 Registrar FEB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 16b per fiberatment of Health and Mental Hygiene? 04636 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death - Month **Physician** 90100 Johnson tebruari 16,2008 /Medical acility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner N/A If Under 24 H/s. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1☐M 2☐F Days Hours 233-58-7915 Director Feb. 28, 1936 West Virginia 71 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Maryland N/A 1. Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Medical Examiner must be notified. Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2905 Rockrose Avenue 21211 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Black 1 ☐ Yes 2 No Specify. 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 7 salth and Mental Hygiene. n 27 Is marked other than "r Norfold Elementary/Secondary (0-12) College (1-4or 5+) & Southern Railroad RAILROAD Worker 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gracion M. Johnson, Sr. Mary Russell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 833 Treeline Dr. Conyers, Georgia 30094 Charles Johnson/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Greenmount Cemetery 20/08 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Euneral Service License 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 Marr 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical (or as a consequence of) Examiner cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tran Due to (or as a consequence of) Box 68760. attending physician pe Physician/Medical the as 1 IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9□Unknown 9 ☐ Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 Tyes 2 No 3 Probably 4 donknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy performed 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 2 ☐ ER/Outpatient 3□ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Hospital or Attending Pl 24 hours after death.
 Funeral Director: After the 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending Injury 1 Yes 2 No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) . Name and address of person who completed cause of death (Item 23a) (Type, Pri 31. Date filed (Month, Day, s Signature Year, Registrar State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Johnson 1524 PM abseth February 2008 /Medical 4c. County of Deat 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner Agnes Hospita LAMORE Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (Country)
Dec 2641944 North If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days 1 □ M 2 🔀 🕏 Director Cardina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notified at 1 es 2 No Directo more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Examiner Black, White, 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ Noþ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retifed) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Me  $\gamma, T, A$ Elementary/Secondary (0-12) College (1-4or 5+) 12th Ocess 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fi Department of Health and Mental H Important: If item 27 is marked ot any injury or other traumatic even ဂ unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Common 2N. Bernice Ave - ouis Eadd LAW Baeto, md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐Removal from State 2-22-0 -10N 4 Donation 9 □ Other (Specify) 2 21. Signature of Funeral Service License 22. Name and Address of Facility 23a. Part1/ Enley he risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirts, or lear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat C se (Final disease of andition resulting in death) theumonic **Physician** Unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed burial-trai Due to (or as a consequence of): physician Physician/Medical the as for use a IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alice Tang 900 Catch Ave Buttmcre, mb 21229 Alice Tang 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Rai Feb 2008 /Medical mer 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Hall 6. Sex 120 M 2□ F Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday Date of Birth (Month, Day, **Funeral** Hours Year 3-24-299 83 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f sh notified a 1 ☐ Yes 2 No Funeral Director BALTI MORE 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or 220 . Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc parmit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", or ite 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 whit 3 ☐ Widowed 4 ☐ Divorced Be Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) inkerton Elementary/Şecondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 mma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2122() . Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) arilyn Middle 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation injury or 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) kds Baltimore MDZ1234 22. Name and Address of Facility. 21. Signatule of Funeral Service Licensee Evans Funeral Chapel+C remation Servicestarbulk 23a. Part1. Enter the disease, shock, or heart failure. death. Do not enter the mode of dying, such as cardiac or a spiratory arrest Immediate Cause (Final \ **Physician** TRUCTIVE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner and the burial-trar resulting in death) Last Due to (or as a consequence of): attending physician Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy signed by the atter in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 Yes 2 No ဥ 2 ☐ ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After Certification: Natural Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ∏ No 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29d. Date signed (Month, Day, Year)

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Registrar

31. Date filed (Month, Day,

Year)

1 9 2008

32. Registrar's Signature

1. Decedent's Name (First, Middle, Last)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death Month

	Physician /Medical
	Examiner
	Examiner
ı	uneral

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. or 28a-f show a notified at or be ral", or Items 23a Examiner must b "natural", permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event;

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

and Division or Vital Records, P.O. Box 68760 attending physic the Hospital or Attending Director:

220-36-3891 Director Usual Residence of Decedent 10c. City, Town or Location 10h County Maryland Baltimore Directo Essex 10e. Street and Number 10f. Zip Code 1622 Riverwood Road 21221 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2221No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 □ Yes ŽŽNo þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Noble Boyer Ann Merling 19a. Informant's Name/Relationship (Type. Print) Donald Richard Jenkins (Husband) 1622 Riverwood Road, Essex, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 10 Other (Specify Entombrent Holly Hill Mem Garden 02/19/2008 Middle River, Maryland 21. Signature of Funeral Service Licensee 50 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Arterioschantic (endicovascular Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2XXVo 4□Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Completed 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury a Work? Injury 1XXVatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 .Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature 29c. License number 30. Name and address of person who completed cause of death Item 23a) (Type, Print) Hill CT. Lutherville, Md 2109 2/10 MD Trimble 6 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Margaret Ann Jenkins 16, 2008 9:34 A M February 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore 1622 Riverwood Road Essex 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 01/16/1940 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Days 68 1 □ M 280XF Maryland 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian. Black, White, etc. Specify: White 16b. Kind of Business/Industry Own Home

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22. Name and Address of Facility Bruzdzinski Funeral Home P.A.

1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Were autopsy findings available prior to completion of cause of death? 1 ∐Yes 2 No

26. Place of Death (Check only one)											
her: 4 🗆 Nursing H	lome	5 Residence	6 □Other (Specify)								
		Describe how inju									

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dav. Year)

State Registrar

within 24 hours a To the Funeral L

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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Year)

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31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

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	Dharia		1. Decedent's Name (First, Middle, La	st)							2. Date of I	eath	Day	Year	3. Time of Death
	Physici /Medi		Richard William	Jacobs, Sr	•						Februa		$\frac{13}{13}$ , 2		8:30 P. M
Ş.	Exami	ner	4a. Facility Name (If not institution, given 4432 Clydesdale				4b. City, To	own, or <b>tim</b> o		of Death		1		y of Death	
4.	Francis	-	5. Social Security Number 6. 5		ie (In vrs. la	ast birthday)	If Under 1		If Under	24 Hrs.	8. Date of E	Birth	N/		lace (State or Foreign
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	3a or	D	4432 Clydesdale	Avenue			1011 225	212	211					JSA	,
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215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes & If Yes, Give Year or Dates:	No		Tes, specin		Specify:	n, Fuenc	nican, etc.)			<sub>ck, White,</sub> fy: Whit	
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	Physician /Medical Examiner		23a. Part1. End the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause on each line.  a	bro	Do not ent	er the mode	of dying	g, such as	cardiac	or respiratory	arrest,			Approximate Interval Between Onset and Death 2
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68760,	te be exectly sician and he burial-tra	edical Exa	resulting in death) Last  Due to (or as a consequence of):  d.												
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3□	]Ectopic preg ] Other <i>(sp</i> ec		_					ate of delive	ery Day Year
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or Vital Records,		Completed									24a. Wa aut pei 1∐ Yes	opsy formed	2	prior to cor death?	psy findings available npietion of cause of
Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Otho		of Deat	h (Check only	one)			
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Division	al or Attences after death	Certification:	3 Suicide 6 Could not b		ury - At hor c. (Specify)	me, farm, stre )	eet, factory, o	office		- 27A	28f. Location City or 7	(Street own, St	and Num ate)	ber or Rura	l Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical C		nysician: To the best niner: On the basis o and manner sta	f examinati		vestigation, in	n my op	oinion, dea			e, date	and place	, and due to	the cause(s)
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l	0'		30. Name and address of person who	completed cause of d	30 Fo	23a) (Type, 1	Print)	ball	himon	e, 1	10 21	211	1		

Registrar
DHMH 17 Rev 1/2001

State

		-	For State Registrar	State	of M	arylan		artmen r <i>tificat</i>			and M	ental Hy	giene Reg. No	CU	08	04643
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	sicia edica		Maureen Flynn	Johnson								Februa	ary 1	.3,	2008	1:15 P M
	mine		4a. Facility Name (If not institution		number)			4b. City,	Town, or	Location of	of Death	·	40	. Count	y of Death	
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Fune	ral		5. Social Security Number	6. Sex 1 ☐ M 2 🖾 F			last birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of B	irth ay, Year,	)	Coui	place (State or Foreign
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and w		-	Usual Residence of Decedent  10a, State 10b, County			10c. City	, Town or Lo	cation							1.	10d. Inside City Limits
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ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If them 27 is marked other than "natural"; or thems 23a or 28a-f show the than the Maryland Company.		-	Sharon H. Flynn	/ Daugr	iter	look D				Str		Eugene				
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permit. Pages 1 and 2 Department of Health a Important: If item 27 is	once		21. Signature of Funeral Servio	Licen	_ 1	40089	Ro 6 75	bert A 57 Wi	Pum Pum Lscon	phrey isin	Funera Ave.,	al Home/ Betho	Bethe esda,	sda- MD	Chevy 2081	Chase, Inc. 4-3501
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Physici	an		Immediate Cause (Final disease or condition	Cor	onai	rv Ar	tery D	iseas	se							Onset and Death  6 years
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w requires that the death cer been signed by the attending		nysician/Me	23b. Was decedent pregnant in the past 12 months?		e birth	2 🗌 Feta	Ideath 3[	Ectopic p					- 12		ate of deliv	ery Day Year
the a		/sic	1 ☐ Yes 2 🛣 No 9 ☐ Unknown		egnant a known	t time of de	eath 5L	Other (sp	oeciny)							
hat the deby	i	5	Part II. Other significant condition	ns contributing to	o death b	out not resu	ulting in the u	nderlvina c	ause give	en in Part I		23e, Did	tobacco	use cor	ntribute to 1	the cause of death?
ires t		ò	anorexia nervos	_			-		_					2 <b>2</b> No	3 ☐ Pro	
been redu		Completed										Fa				
e law has l	3	ᇍ										24a. Wa	s an opsy formed?	246	. Were autoprior to condeath?	opsy findings available empletion of cause of
t: Th	2 6												2 <b>X</b> N	0	1 ☐ Yes	2□ No
ician certifi		Re	25. Was case referred to medical examiner?	Hospital:					Othe	or.		(Check only				
this a	. I	9	1 ☐ Yes 2 ☐ No 27. Manner of Death	1	☐ Inpatiente of Inju		ER/Outpatier 28b. Time o		JA	4 LI NL		me 5X Res 28d. Describe				fy)
ling		<u> </u>	1 ☑ Natural 5 ☐ Pendin	g (N	lonth, Da	ay Year)	Injury	м [	28c. Injun Work	yaı ⟨? Yes 2∐		zou. Describe	a now inju	Try Occu	irrea	
ttend death		Certification:	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	not be	aco of ini	iury . At bo	ome, farm, str			163 2 🗆		20f Location	(Ctroot o	and Nun	hor or Pur	al Route Number,
or A or A Direction			4 ☐ Homicide determ	ined 206. Fi	ilding, e	tc. (Specify	y)	eet, lactor	y, onice		1	City or To	own, Stat	te)	iber or nur	ar noute runiber,
pital purs a purs a eral l	9		29a, Certifier 1   ☐ Certifyir	g Physician: To	the hest	of my kno	wledge deat	h occurred	at the tin	ne date ar	nd place	and due to th	a cause/	s) and r	nanner as	stated
Hos 24 hc Fun	:	edical		Examiner: On th		of examina										
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in but the funeral directory and 0.	5	ĭ ĭ	29b. Signature and title of certifie			1	<del></del>	29	c. License	e number			29d. Da	ate sign	ed (Month	Day, Year)
H 3 F C			10/2	(Tom n	inni	5	an I	2	ו מת	115			Foh-	C11 O T	v 1 /.	2008
1		-	30. Name and address of person	who completed o	Susp of	leath (Itam	23a) (Type	Print)	חצו	113			repi	ual	у 14,	2000
ろし			Lee Pennington,						Sui	te 10	00, E	Betheso	la, M	lary	1and	20817
	Stat		31. Date filed (Month, Day, Year)			rar's Signa		Soul								
Rec	istra	-	ern 1	e 2008	e to	6.000	All A	63134	E and							

DHMH 17 Rev 1/2001

			1 - For State Registrar	(	-		d / Depa		t of H	ealth a		lental Hygi	_	08	04644
	Physic	an	Decedent's Name (First, M.	fiddle, Last)								Date of Death     Month	Day	Year	3. Time of Death
	/Medi		ROSE			LEE			JAF	FE		FEBRUARY	17	2008	COSAM
	Examir		4a. Facility Name (If not instit	ution, give stre	et and number	r)		4b. City,	Town, or	Location of	of Death			y of Death	
			JEWISH CON	ALESCE	NT & NU	JRSING	à	BAL1	LIMOR	RE		BALT	BALTIMORE		
	Funeral Director		5. Social Security Number 213-28-5079		7. A	Age (In yrs.	last birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 08/06/	1930	9. Birthpl Count	ace (State or Foreign ry) MD
	and w		Usual Residence of Deceder 10a. State 10b. Co			10c. Cit	y, Town or Lo	cation				-		10	Od. Inside City Limits
	r 28e-f show	Director	MD BA	LTIMOR	-		WINGS	MILLS							1 ☐ Yes 2 No
	章 0 間	占	10e. Street and Number	E DUN 4	TOUR			10f. Zip		17		10	g. Citizen of	What Coun	ry?
	s 23a	Funeral	10204 CASCAD			4. C	5 10		211				USA		. India
		'n	11. Marital Status  1 Never Married 2		Armed Forces	?	.5. 13.	lf Yes, spec	ify Cuba	spanic Ori n, Mexicar	gin? (Spe 1, Puerto I	cify Yes or No- Rican, etc.)		ce - America Ick, While, 6	itc.
36	hours after turel', or Ite	by	3 ☐ Widowed 4 ☐ Divo		1 ☐ Yes 2X If Yes, Give Year or Dates	7140		1 ☐ Yes 2	2 <b>X</b> No	Specify:			Specia	<sub>fy:</sub> W	HITE
21215-0036	72 hours naturel', dical Ex			ident's Educat			l 16a Dece	dent's Usua	I Occups	ution		1 1	6b. Kind of B	Rusiness/Ind	uetn.
5	C 2 3	Completed	(Specify only h	ghest grade c	om <i>pleted)</i>		(Give	kind of wor DO NOT us	k done d e retired	<i>luring</i> mos	t of worki	ng ''	DD. KHIQ OI E	ousiness/inc	ustry
7.	with ene. ther	шc	Elementary/Secondary (0- 12	2)	College (1-4or	r 5+)				WNER			PACK	AGE L	OUOR
	filed Hygi Sther	ပိ	17. Father's Name (First, Mic	dle, Last)					Ť		r's Name	(First, Middle, Ma			
Maryland	d be ental ced c	8	HYMAN			R	IRENBA	IIM			STHER	•		•	RIED
2	mark meti	၉	19a. Informant's Name/Relat	ionship /Tvpe	Print)	D			(Street a			l Route Number,	City or Town		
Ma	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importants: If item 27 is marked other then may injury or other treumetic event, ITEM ADICE.		NATHAN JAF		•							RT, OWING			
Ġ,	1 an Heal tem 2		20a. Method of Disposition	,	30071110	20b. P							oc. Location		
Baltimore,	ages nt of r: If it		1 XBurial 2 ☐ Cremat		oval from State	• Lបឹ	BAWY 72 BARI CO	"AUSA	CH <sup>olace</sup>	3)	00/10				
臣	it. Purtme		'4 □Donation 5 □ Othe					NG. . Name an				3/2008 DL LEVINS	ROSED		
Ba	Department of the permitted of the permi		1 Signature of different Section 1	11	/	5									MD 21208
			Taluk !	X \ /(	emi	1									
H	Physician	9 1	23a. Part 1. Enter the bisease, or comblications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Ptofound vas unar demandia  Due to (or as a consequence of):  Saturatially list conditions.  Saturatially list conditions.												Approximate Interval Between Onset and Death
	/Medical		resulting in death)	a	Due to (or a	-	uence of):		•						0 0 0
,760,	ysician and he burial-transit	cal Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or a	· ·	uence of):	cere	bri	vas	sul	ar acc	iden	+ >	6 months
P.O. Box 687	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnanin the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	d	If yes, outcom 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal	death 3	Ectopic pre			386 - 31			ate of deliver	y Day Year
Д,	s thai ned t	by P	Part II. Other significant con										cco use con	tribute to the	e cause of death?
rd <sub>S</sub>	n sig	d b	Hyperts	usion	clu	rouic	atr	ial:	lib.	rilla	tion	1 ☐ Yes	2 No	3 🗌 Proba	ıbly 4 □Unknown
Records,	w requir been si should	Completed	11				•		3		,	24a. Was an	24h	Were autor	sy findings available
Be	The law	m d										autopsy	L.	prior to condeath?	pletion of cause of
a	icien: Th certificate rector, pag	e C	25. Was case referred to me	4:1									No	1 Yes	2□ No
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of	ding Physicien: h. After this certific funeral director,	. To	27. Manner of Death		1 ∐ Inpat 28a. Date of Inj		ER/Outpatien 28b. Time of		A Bc. Injury	4 4		ne 5 Residen 28d. Describe how			)
DO	ding F h. After funera	tlon	1 Natural 5 □ Pe		(Month, D	ay Year)	Injury	М	Work	? ′es 2		.ou. Doscribo no v	inquity occur	1100	
S	deat deat ctor: / the	ica	3 ☐ Suicide 6 ☐ Co	uld not be	28e. Place of Ir	niuny - At ho	me farm str			03 2 🗀		28f. Location (Stre	et and Num	her or Rural	Route Number
Division	f or Attendi after death. Director: A I in by the fu	Certification;	4 Homicide de	ermined '	building, e	etc. (Specify	()	eet, ractory,	OHICO			City or Town,		oer or nurar	Houle Walliber,
J	pitel purs surra erel l		29a. Certifier 1 Cert	fulas Dhusiai	T - 4b - b	h of	11 11								
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	one) 2 Medi	cai Examiner	On the basis	of examinal	tion and/or in	estigation,	in my op	inion, deal	th occurre	and due to the cau	e and place,	and due to	the cause(s)
	To Too	-	230. Signature and title of cel	$\mathcal{M}$	00	111		290.	License	number	_	290	a. Date signe	Month, L	ray, Year)
			<b>F</b>	00	yam,	4000		L	OC	7 > 3	92	8	-111	120	08
	3		29b. Signature and title of cer  30. Name and address of per  2434 W  31. Date filed (Month, Day, Y	BEL	tered cause of	RE (Item	23a) (Type, <b>AVE</b> NI	Print) S	BAL	AIYA TIN	BE 1DRI	E, MD.	MD - 21.	215	
•	Sta Registr	te ar	31. Date filed (Month, Day, Y	1 9 200	32. Flogist	trar's Signal	ture	and.	,						

Physic /Med Exami

**Funera** Director

"natural", or items 23a or 28a-f show sdiest Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician /Medica Examine

Division or Vital Records, P.O. Box 68760,

	for State Registrar		Olato of I	viaiyiai			te of l			ional Hy	Reg. No	20	08	046	45
ian	1. Decedent's Nam	e (First, Middle, La	st)			7 ,				2. Date of De Month	eath Da	ay _	Year	3. Time of D	
ical	Varvar				amich		S y, Town, or	Logotion	of Doath	Febru	-		2008 of Death	20:35	PIM
ner		f not institution, giv		er)			moniu		OI Dealii		40		timor	e	
	5. Social Security N		Sex 7.		last birthday		er 1 Year	If Under	24 Hrs.	8. Date of Bi	rth av. Year			lace (State or i	Foreign
	218-64-4	4/1	I□M 2 <b>∑</b> F	7	5 Yrs.	MOTTUR	Days	riodis		August .	30,19	32	Athen	s, Greeo	e
7	Usual Residence o 10a. State	f Decedent 10b. County		10c. Cit	y, Town or L	ocation							1	0d. Inside City	Limits
ţō	Maryland	Baltimo	re		Timoni	um								1 ☐ Yes 2	No No
Funeral Director	10e. Street and Nu	mber				10f. Z	ip Code				10g. C	itizen of	What Cour	ntry?	
ra D	11920 Ma	ys Chapel	_				2109					U.S		Indian	
nue	11. Marital Status		12. Was Decede Armed Force	s?	.S. 13.	Was Dec	edent of H ecify Cuba	ispanic O an, Mexica	rigin? (Sp an, Puerto	ecify Yes or No Rican, etc.)	0-		ce - Americ ck, White,		
by F	1 ∐ Never Mar 3 X Widowed	ried 2 Married 4 Divorced	1 ☐ Yes 2] If Yes, Give Year or Date	S) NO		1 ☐ Yes	a¥ No	Specify	<i>:</i>			Specif	y: Whi	te	
ted	(Sno	15. Decedent's Ecify only highest gra	ducation		16a. Dece	edent's Us	suai Occup	ation	st of work	dina .	16b. l	Kind of B	usiness/in	dustry	
nple	Elementary/Sec		College (1-4	or 5+)			vork done o use retired	1)	0, 0, 1, 0, 1	9					
S	6 years	(First, Middle, Last	*)		HO	ısewi	.te	18. Moth	er's Nam	e (First, Middle	_	n Surnai		<u></u>	
To Be Completed		os Athana								Athanas					
-	19a. Informant's N	ame/Relationship (	(Type. Print)							ral Route Num					
	Marianna	Alevrogi	annis D	augther						, Timor					93
	20a. Method of Dis 1 Burial 2	position ☐Cremation 3 ☐	Removal from Sta		Place of Disponentery, cre					uary			- City or To	yland	
	4 □Donation	5 ☐ Other (Special	fy)	Oa	k Law			<u> </u>	21,	2000				yrand	
	Out	uneral Service Lice	Conv	ell	In !	Conn∈ 7110	Solle	runer ers P	al H oint	ome Of Road,	Dung	dalk dalk	,P.A. ,MD.	21222	
	23a. Part1. Enter shock, or he	the disease, or com art failure. List only	plications that cau	sed the deat	h. Do not er	nter the m	ode of dyir	ng, such a	s cardiac	or respiratory	arrest,			Approximate Interval Betw	een
	immediate Cause disease or condition	(Final	_a	I	ehy!	Dra	tion	)					,	Onset and De	eatii
	resulting in death)		Due to (or	as a consec	uence on:		100							1 ( = = = =	
e.	Sequentially list or if any, leading to it	onditions, mmediate	b Due to (or	as a consec	pew juence of):	Len	17/1							years	
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	resulting in death)	Last	Due to (or	as a consec	uence of):										
Aedical			d												
/Me	IF FEMALE:		23c. if yes, outco	me pf pregn	ancy							23d D	ate of deliv	erv	
23c. If yes, outcome pf pregnancy 1											ear				
hysi	9 Unknow	n	9□Unknow												
ğ	Part II. Other sign	ificant conditions	1 .			A		en in Part	i I.				ntribute to t 3 □ Pro	the cause of de	eath? nknown
Completed		1	13 ThmA	1	eep,	TPN	CA					2 No			
mple							_			24a. Wa aut per	s an opsy formęd?	246	prior to co death?	opsy findings a ompletion of ca	iuse of
S	25. Was case refe	rred to medical						26 Plac	re of Dea	1  Yes ith (Check only		No	1 ☐ Yes	2□ No	
To Be	examiner?	No No	Hospital: 1 ☐ Inp	atient 2	] ER/Outpatie	ent 3	DOA Oth	or.	Nursing H	**		6 □01	ther (Spec	ify)	
n.	27. Manner of Dea		28a. Date of	Injury <i>D</i> ay Yea <i>r</i> )	28b. Time Injury		28c. Inju	ry at rk?		28d. Describe	e how in	jury occu	irred		
catic	2 Accident	investigatio	on			М		Yes 2	□No		(2)			- / D 4- M	
rtific	3 ☐ Suicide 4 ☐ Homicide	determined	1 28e. Place of	injury - At h , etc. <i>(Sp</i> eci	orne, tarm, s	ireet, fact	югу, опісе			28f. Location City or T	own, Sta	ana Num ate)	iber of Hui	ral Route Numb	uer,
al Ce	29a. Certifier	1 Certifying P	hysician: To the b	est of my kn	owledge, dea	ath occurr	ed at the ti	me, date	and place	, and due to th	ie cause	(s) and n	nanner as	stated.	
Medical Certification:	(Check only one)	2 ☐ Medical Exa	miner: On the bas and manne	is of examin	ation and/or	investigat	ion, in my	opinion, d	eath occu	irred at the tim	e, date a	and place	e, and due	to the cause(s)	)
1 ==	00h	d title of certifier					29c. Licens	se number	r		29d. F	Date sign	ed (Month	, Day, Year)	

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SchWARTZ

Attending MD

MD

ORIGINAL

3512

D17118 Feb 18, 2008 Newland Rd 21218

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** S. Ketchum Month February 16, 2008 6:04 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Transitions Healthcare Carroll Co. Sykesville 8. Date of Birth (Month, Day, Year) Feb. 22,1924 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🛣 F 220-12-5912 Director Maryland 83 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show other then "natural", or items 23a or 28a-f shower, the Madical Examiner rount by notified at Dundalk 1 ☐ Yes 2X No Baltimore Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2744 Plainfield Road United States 21222 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ∐ Yes 2 ∰No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2KNo Specify: Specify. Š 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fife Department of Health and Mental Hy Important: if Item 27 is marked oth any linjury or other traumatic event 2008. 18. Mother's Name (First, Middle, Maiden Sumame) Be Frederick Schenk Sophia Toepfner 19a. Informant's Name/Relationship (Type, Print) Grandson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward A. Ketchum, IV 504 Bayside Drive Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 2/20/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Dundalk, Maryland 21222 7922 Wise Ave. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclero /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) physician Box 68760, Physician/Medicai attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ cete hes been sig , page 2 should b Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Minknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 1 Yes 2 No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Dther: ←S Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After s after dea...ral Director: Aftr 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43725 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) idye Road Westminister MD 21157. MAHMOOD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

08-00868 Paul Klein

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 04647

r aut Mein		For State	Otati	0 01 11101 )		Certific	ate of	Death					Reg. No	).	_ 0 0 0	
Physician	1 1	egistrar . Decedent's Name	(First, Middle,L	ast)				Kle	——- in		1-	Date of D Month January	Dav	Year		me of Death 010 hrs
Med Examine	-	Paul a. Facility Name (if	not institution (	nive street and	number)		41	b. City, Tox		ocation of I		<u>oarroar</u>		c. County o	f Death	
	1	Sinai Hospit		9,1000000	,			Baltimo	ore						Lo 6:4:-	- (Chata as
Funeral	5	. Social Security N	umber 6.	Sex	7. Age	(In yrs. last bir	thday)	If Under Months	1 Year Days	If Under 2 Hours	24Hrs. Min.				9. Birthplac Foreign Country)	
Director	1	216-58-	1974 1	<b>X</b> M 2 F		57	Yrs.	Wionans	Bayo			09	30	50	Country)	FID
<b>X</b>		Jsual Residence of	Decedent 10b. County		- 1	0c. City, Towr	n or Location	on								Inside City Limits
ow any	l	10a. State MD	NA			Balt									_	Yes 2 No
ryland a-f sh	힑	10e. Street and Nur	mber					10f. Zip C	Code				10g. 0	Citizen of Wh	nat Country?	
S he Man	ě	1803 Th		ry Ro	ad				212						S.A.	
death with the Maryland or items 23a or 28a-f show must be notified at once.		11. Marital Status		12. Was I	Decedent E	ver in U.S.	13. Wa	s Deceden es, specify	t of Hisp Cuban,	anic Origir Mexican, I	n? ( Spe Puerto F	cify Yes o Rican, etc.	r No- )	14. Race White	- American I	ndian, Black,
death or item	٩Į	1 X Never Marrie		1 Ye	s 2x	No	1	Yes 2	_					Specify:	Bla	
	ᆰ	3 Widowed  15. Decedent's Ed		ced If Yes, Give or Dates:		pleted) 16a	Docoden	r'e Henal C	occupation	on (Give ki	ind of w	ork done	16	b. Kind of Bu	siness/Indus	stry
2 hour "natu	Completed	Elementary/Seco			е (1-4 ог 5		during m	ost of work	ing life.	DO NOT U	ise retire	ea)		Oh i		
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State of Manyland / Department of Health and Mental Hydiene

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To the Ho within 24   To the Fu	Medical	29b. Signature and title o		and manner	stated.			c. License				29d. Date	e signed (M	onth, Day, Year)	
	٦	1/1/	1.	10/11	M			O.C.M	1.E.			Februa	ary 15, 20	80	
<b>\</b>		30. Name and address of	person who	completed ca	use of death (Ite	em 23a)									
H		Melissa Brassell	MD A		ledical Exam		1 Penn St	treet, Ba	altimore, M	D 2120	)1				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician DOROTHY GNALL KAPLAFKA FEB 12 2008 10:25 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 M 2 X Director 171-26-6289 73 July 15, 1934 Pennsylvania Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 ☐ Yes 2 X No be notified Director Schuylkill Mahanoy City Pennsylvania 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō Items 23a Funeral 17948 United States 518 Morea Road Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☒ No Specify. Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. Coal Company Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Mary Stelmak Joseph Gnall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If Item 27 is
any Injury or other trau 518 Morea Road, Mahanoy City, Pennsylvania 17948 Steven Kaplafka / Husband 20b. Place of Disposition (Name of Inclientery, crematory or other place)
National Cemetery 20a. Method of Disposition 20c. Location - City or Town, State February 19, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2008 Annville, Pennsylvania 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave. Bethesda, Maryland 20814-3501 21. Signatu e/of Funeral Service Licenses M01473 23a. Part. Enter the disease, d complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DIFFUSE ALVEOLAR HEMORRHAGE resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal dea 4 Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Month 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown the 9☐Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed certificate 1 ☐ Yes 2**X** No Yes Yes 2□No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔯 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury 27. Manner of Death 28b. Time of I Director: After the 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide determined within 24 hours a To the Funeral C 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0101235221 (VA) 02,13,2008 NATIONAL NAVAL MEDICAL CENTER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BETHESDA MD 20889-5600 ON S. YUN filed (Month, Day, Ye MC USN LCDR 32. Registrar's Signature Year) State Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** I RWIN KUFF 0330 AM 2008 Fobruary 16 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NORTHWEST HOSPIT AL BALTIMORE RANPALLSTOWN If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Year) 04/07/1928 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 216-24-1033 79 MD Director Usual Residence of Decedent death with the Maryland show 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f shovidical Examiner must be notified at 1 ☐ Yes 2 X No Director MD N/A BALTIMORE 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 6317 PARK HEIGHTS AVENUE, #207 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No WWII If Yes, Give Year or Dates: NAVY Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the OPTICAL TECHNICIAN OPTOMETRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill Health and Mental H tem 27 Is marked oth Be HERBERT **KUFF ESTHER** FRIBUSH traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 BEATRICE KUFF / WIFE 6317 PARK HEIGHTS AVENUE, #207, BALTIMORE, MD permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemelars cremators or other place)
MEMORIAL PARK 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ABurial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/18/2008 REISTERSTOWN, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a cor sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last prevenione Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2▼ No 24a Was an page 2 s autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2X No 1X Inpatient 2 ER/Outpatient 3□ DOA Certification: To this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Pruneral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 THomicide Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D0059736 16 h

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Registrar's Signatur

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 50% Dav Year **Physician** ewi5 2008 Chruary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Sinai NOSD ta 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 1 M 2 ☐ F 3 Director ashington D.C Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County ns 23a or 28a-f show must be notified at 10d. Inside City Limits BAHIMORE Director 1 XYes 2 No MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "-- any Injury or other traumest. 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: ģ Specify: African American 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Spore man 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis Sephine Carlano 2 19a. Informa t's Name/Relationship (Type. Print) BAHIMORE, MARYLAND 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signate of Funeral Service Licensee NAMEY M. WALLAC 13405 W. Franklin 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastati **Physician** months /Medical Due to (or as a consequence of): Examiner nd Stage 6 monts Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 ☐ Fetal death 3 □ Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performe certificate 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation (Month, Day Year) To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DOD 6155 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 750 MAIN ST. REISTERSTOWN, MD

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31. Date filed (Month, Day, Year)

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istrar's Signature

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 16, 2008 **Physician** June Meredith Lucas 12:08 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 7326 Tred Avon Road Middle River If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1□ M 3€ Months Days Hours 184-20-3674 81 05/11/1926 Director Pennsylvania Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County d other than "natural", or items 23a or 28a-f show event, the Medral Examiner must be notified at 1 ☐ Yes 20 TYNo Director Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 7326 Tred Avon Road U.S.A. Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ... any liqury or other traumatic event. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black. White, etc. 1 ☐ Yes 🐉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XX No Specify. þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Garner Meridith Sweet Anita Mae Schultz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richard Lyle Lucas, Sr -Husband 7326 Tred Avon Road, Middle River, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial XXCremation 3 ☐ Removal from State Bayview Crematory Inc 02/20/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 21. Signature of Funeral Service Ligensee 1407 Old Eastern Avenue, Essex, Maryland 21221 April. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MONSMALL CIEL disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-trant Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year detached for Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy perform 1 ☐ Yes XX No 1□ Yes XX No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Amesidence 6 Other (Specify) 1 ☐ Yes XX No 2 ER/Outpatient 3 DOA ပ this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0058475 PHYSTUTAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHOUSE NOVATOUMS 9114 PHZLADZE PHIA ROAD BAC 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 1100 Jeburary 2008 99. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner KO 50 dal salt Square If Under 24 Hrs If Under 1 Year 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 4 217.70.1909 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number GNP. 21321 Funeral £000 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married fimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Blac Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the Manal injury or other event the Manal injury or other event the Manal injury or other event the Manal injury or other event the Manal injury or other event the Manal injury or other event the Manal injury or other event the Manal injury or other event the Manal injury or other event the Manal injury or other event the Manal injury or other event the Manal injury or other event the Manal injury or other event the Manal injury or other event the Manal injury or other event the Manal injury or other event the Manal injury or other event the Manal injury or other event the Elementary/Secondary (0-12) College (1-4or 5+) Health Care Giver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grace E Lee Lips Comb ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Foxward LN Essex, MD 221 labatha Lee-Miginnis 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/20/2008 Baltimore, MD King Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaugnon C Oreene Forerul Services Vaughn C. Moeno. 14905 York India State of each line.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4405 York And Baltimore, MD a DD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner equalitative for office c, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the for use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) n signed by the a Id be detached for P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2 NO funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ♣No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Anatural Injury 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident completely filled in by the 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and tille of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BEhari 31. Date filed (Month, Day, Year)

State Registrar

32. Registrar's Signature

		For State Registrar	State		and / Depa		t of H	ealth ar	nd Me	ntal Hygi	g, No.	) 8	04654
Physicia /Medic		1. Decedent's Name (First, Middle, Dorothy B. 1		ır						Date of Death Month ebrual	y 13,		3. Time of Death 5:00 P M
Examine		4a. Facility Name (If not institution, Carroll Luthe	-					Location of ninst			4c. County	of Death arro	11
Funeral Director		212-07-4122	5. Sex 1 □ M 💹 F	7. Age (In y	rs. last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Min.	Date of Birth (Month, Day, arch 1	Year) 4,191	9. Birthp Cour 5 M	place (State or Foreign ntry) [aryland
ehow	ō	Usual Residence of Decedent  10a. State 10b. County  MD Carro	011		City, Town or Lo							1	10d. Inside City Limits 1 ☐ Yes XXNo
with the M	Direct	10e. Street and Number 359 Grey Fria				10f. Zip	Code	2115	Ω	10	og. Citizen of \	What Cour	
ING 21215-UU36 be filed within 72 hours after deeth with the Maryland tal Hygiene. d other than "natural; or ltems 23a or 28a-f ehow event, the Masilcal Exarctive routified at	by Funeral Director	11. Maritat Status  1 Never Married 2 Marrie  XXWidowed 4 Divorced	12. Was De Armed F	cedent Ever in forces? XXXNo Give		Was Dece If Yes, spe				y Yes or No- can, etc.)	14. Rac	ce - Americ ck, White,	can Indian,
Maryland 21215-0036 d 2 should be filed within 72 hours af th and Menial Hygiene. 7 is marked other than "natural; or treumatic event, the Madical Exerc	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed		life.	dent's Usu kind of wo DO NOT u	ork done d se retired	during most ( )	of working		Autom	nobi	le
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IIIIMOFE, nit. Pages 1 an extment of Heal ortant: If item 2 injury or other		19a. Informant's Name/Relationsh  Linda Wheat /  20a. Method of Disposition  XXBurial 2 Cremation 4 Donation 5 Other (Sp.  21. Signature of Funeral Sorvice L	Daught	201	359 D. Place of Dispo Competery, cre Lake V Pa	Grey osition (Na. matory or ( iew rk 2. Name a	Fr: me of ther place Memo	iars orial	Rd. Date 2/ Eckh	° / '16/08 nardt H	inste 20c. Location Syl Eunera	r, M - City or To kesv 11 Ch	D 21158 own, State rille, MD apel P.A.
		23a. Part 1. Enter the disease, or o shock, or heart failure. List o	complications that	caused the dieach line.								Mil:	Approximate Interval Between Onset and Death
F8/60, ilicate be executed   Medical Examiner   Burial-transit	dical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	o (or as a cons	Sequence of):	838	en	e <sub>t</sub>					4m
HECOTGS, P.O. BOX 681  The law requires that the death certificate site has been signed by the ettending phy page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live	outcome of pre birth 2 F gnant at time o	etal death 3	⊒Ectopic p ⊒ Other (s			=447000			ate of deliv	ery Day Year
Hecords, P. he law requires that he has been signed b age 2 should be deta	leted by PI	Part II. Other significant condition	ns contributing to		resulting in the u	underlying	cause give	en in Part I.			s 214No	3 Prol	the cause of death?  bably 4 □Unknown  opsy findings available
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on of ding Phy h. After this funeral d	ation: To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Dat (Mc	Inpatient 2 e of Injury onth, Day Year	ER/Outpatie		28c. Injun Worl	er: 402 Nur:	sing Home	5 ☐ Reside	nce 6 □Oth		(y)
DIVISION Ital or Attendris effort death el Director: led in by the	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	ned 288. Pla	Iding etc. (Sp	)/_					City or Towr	, State)		al Route Number,
To the Hospital or within 24 hours efter To the Funerel Dir completely filled in	Medical	(Check only 2 Medical E	Physician: To the xaminer: On the and ma	he best of my basis of exam anner stated.	mowledge, dea nination and/	vestigation	n, in my o	ne, date and pinion, death	l place, and n occurred	at the time, d	ause(s) and mate and place,  9d. Date signe	and due t	to the cause(s)
5 × C	-	29b. Signature and title of certifier		bok		23			رمر		_		
Sta Registr		30. Name and address of person v 31. Date filed (Month, Day, Year)	zu lie	use of death (	Som &	Print)	A	Cen	i Su	ud #	201,	we	ch Zeres 24157 remaky M

Please Type or Print in Black Indelible Ink. Ensire All Copies Are Legiblie. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar amend #31 Per DVR G876 2/19/08rt ate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician FEBRUARY 15, 2008 ROXY ANN LAIRD 11:45A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Days Hours Min. 1□ M 2**X** F 85 MARYLAND 16 AN271923 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c, City, Town or Location 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the <u>Medical Examiner must be notified at</u> 1 Yes 2 No Director mo CARROLL 10g. Citizen of What Country? 10e. Street and Number NATIONAL USA 21771 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□Yes 2⊠No 3altimore, Maryland 21215-0036 Specify à INHITE 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 27 is marked other than Elementary/Secondary (0-12) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental BARTON MATHENEY (TEORGE ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MARK B. LAIRD Health a HAMPSTEAU Department of Health Important: If Item 27 any Injury or other tr. once. BOB GROVE ROAD MO 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State EVERGREEN Mem. 4 Donation 5 NOther (Specify) ENTOMBMENT 22. Name and Address of Facility 21. Signature of Funeral Service Licensee NZUMBMN EH & MON CO. SYKESVILLE ELDERSBURGMO Pent 1 Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** as /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Linknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 27 No 3 ☐ Probably 4 ☐ Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 11 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 Tes After this funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Hospital or Attending Natural 5 ☐ Pending investigation within 24 hours arter control to the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Mehonal 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 1 9 2008 EB F Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #30 perDVR, G876, 2/19/08 TT Certificate of Death Reg. No/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8:13A M ELAINE LEVEY 02-16-2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death SUBURBAN HOSPITAL MONTGOMERY BETHESDA 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Min. Months 1 □ M 2 🕅 F Days Hours 199-12-4209 82 PA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits MONTGOMERY 1 ☐ Yes 2 No MD CHEVY CHASE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8100 CONNECTICUT AVENUE 20815 **USA** 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes ② No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🎾 No Specify: WHITE 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) WOMEN'S CLOTHING STORE OWNER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MAX WEISBERGER BERTHA FLEISHER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 91 OLD HYDE ROAD WESTON, CT 06883 MARC LEVEY / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State AGUDAS ACHIM 02/18/2008 WEST PITTSTON, PA 4 Donation 5 □ Other (Specify) 21. Sign for of Fune al Service Ucens 22. Name and Address of Facility SOL LEVINSON & BROS. 3900 REISTERSTOWN RD. PIKESVILLE, N Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part1 Approximate Interval Between Onset and Death Immediate Cause (Final CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHRONIC KIDNEY DISEASE - STAGE V 1 XYes 2 No 3 Probably 4 Unknown TYPE 2 DIABETES 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? 1□ Yes 💥 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

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sician and burial-transit funeral director, Certification: To To the Hospital or Attending in by

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**Examiner** 

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Baltimore, Maryland 21215-0036

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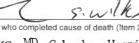
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Medical within 24 ho To the Fun completely Registrar

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31. Date filed (Month, Day, Year) FEB 1 9 2008 State

29a. Certifier



and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) D0063195

02/16/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven David Wilks, MD Suburban Hospital Bethesda, MD

29b. Signature and title of certifie



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year LIVINGSTON BYRON /Medical 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A 1000 8. Date of Birth Birthplace (State or Foreign Country)
 MD 5. Social Security Number **Funeral** 1 M 2 □ F (Month, Day, Year) 03/28/1921 220-05-9867 86 Director Usual Residence of Decedent 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f shov must be notified at 1 Yes 2 No Director MD BALTIMORE CITY BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 or items 23a 3031 FALLSTAFF ROAD, APT. 107-C 21209 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑Yes 2 ☐ No WW I I If Yes. Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married If Yes, Give Year or Dates: ARMY 1 ☐ Yes 2 💢 No WHITE Specify 3 Widowed 4 Divorced al Hygiene. I other than "natura went, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN JEWELRY BUYER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked MEYER LIVINGSTON HALPERN MINNIE ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If item 27 is RAISA LIVINGSTON / WIFE 3031 FALLSTAFF ROAD, APT. 107-C, BALTIMORE, MD 20b. Place of Disposition (Name of cematary, crematary of other place)
MEMORIAL PARK Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State injury 4 ☐ Donation 5 ☐ Other (Specify) 02/17/2008 REISTERSTOWN, MD 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 12702711 /Medical Due to r as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed sician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical as the asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the atten e detached for u 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an page 2 autopsy certificate perform 1 2 NO 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2[X No 1\_npatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death Date of Injury (Month, Day Year) e Hospital or Attending P 24 hours after death. e Funeral Director; After t 28b. Time of 28d. Describe how injury occurred After 1 Certification: 28c. Injury at Work? Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide thin 24 hours a 29a, Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0

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DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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· · ·		egistrar I. Decedent's Name (First, Middle, Last)	Certificate	Death	2. Dat	Reg. No. e of Death		. Time of Death
Physicia Medical Exami	. 11 17	Reginald Andrew Murphy				oruary 8, 200		1324 hrs
$C^{-}$ ,		4a. Facility Name (if not institution, give street and not 422 Burbank Court	umber)	4b. City, Town, or Location Halethorpe		В	County of Death altimore Coun	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)		Under 24Hrs. 8. D	ate of Birth (MM/	DD/YYYY) 9. Birth; Foreign	
Director		156-86-2596   X M 2 F	20 y	rs. Months Days Ho	ours Min.	Feb. 3,	1988 Coun	try) PA
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with the same no 23a	ᇛ	11. Marital Status 12. Was De	cedent Ever in U.S. 13. V	Vas Decedent of Hispanic			14. Race - America	n Indian, Black,
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after o	by F	3 Widowed 4 Divorced If Yes, Give Ye or Dates:	ar 1	Yes 2 X No spec				lack
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	٩	19a, Informant's Name/Relationship (Type, Print) Burnett McFaden, mothe	r 19b. Mail	ing Address (Street and 2 Burbank Ct	Number or Rural F Halet	Route Number, C horpe, l	ity or Town, State, $MD_{ullet} = 2122$	Zip Code) 7
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	Σ	29b. Signature and title of certifier		O.C.M.E.			bruary 9, 2008	
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7		<ol> <li>Name and address of person who completed ca Donna M. Vincenti, MD Assistant</li> </ol>		11 Penn Street, Bal	Itimore, MD 2	1201		
	tate		Registrar's Signature	Al. II				
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Physician: r this certific ral director,	2	1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatien		4 Inursing Hom				ý)
ling F After	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year)	28b. Time of Injury	28c. Injur Wor M 1 П		8d. Describe	how injury occu	rred	
Attending r death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury - At ho	me farm stre		Yes 2 □ No	Rf Location /	Street and Num	her or Rus	al Route Number,
lor A after Direction by	Certification:	4 Homicide determined building, etc. (Specify	/)	out lastery, emiss		City or To	wn, State)	DOI OI TIUIC	a riodio ridinos,
sspita nours ineral y filled		29a. Certifier 1 Certifying Physician: To the best of my know							
To the Hospital or Attending Physwithin 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	Medical	(Check only one) 2  Medical Examiner: On the basis of examinat and manner stated.	tion and/or in	estigation, in my c	pinion, death occurre	d at the time,	, date and place	, and due t	o the cause(s)
To t To t	Σ	29b. Signature and title of cartifier		29c. Licens			29d. Date sign	ed (Month,	Day, Year)
0		M.D.		Doc	062573.		2/1	2/08	•
7		30. Name and address of person who completed cause of death (Item			Λ		A	_	7 -
Sta	te.	DR Debro a. Hattens 9000 FRA.  31. Date filed (Month, Day, Year)  FFR 1 9 2008	1KLIN S ture	QUEFE	Vr Ball	imor	e Md	210	237
Registr		FEB 1 9 2008 January 2	N Age	A Standard					

			For State Registrar	State of Mar	yland /		artmer rtifica:			and M		giene Reg. No. 2	11118	04660
¥	Physici		Decedent's Name (First, Middle, La Paul	st) Madzara	ac						2. Date of De Month <b>Februa</b> 1	Day	2008	3. Time of Death 9:35 PM
	/Medic Examin		4a. Facility Name (If not institution, giv				4b. City	Town, or	Location of		1 001 001	4c. Co	unty of Death	
			Riverview Nursing 5. Social Security Number 6.5		In yrs. last i	hirthdayl		ssex r 1 Year	If Under	24 Hrs	8. Date of Bir		altimo	re place (State or Foreign
В	Funeral Director			nex 7. Age (. IXM 2□F	88	Yrs.	Months		Hours	Min.	January	16 <b>,</b> 1920	Betr	Tehem, PA.
	and w		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, To	wn or Lo	ocation							10d. Inside City Limits
	Maryl a•f sho ified a	ctor	Maryland Baltim	ore		Dui	ndalk							1 □Yes 2 XNo
	h with the 23a or 28 st be not	Funeral Director	10e. Street and Number 712 51st Street				10f. Zi	212	22			10g. Citizer	of What Cou USA	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 Never Married 2 Married  Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 AYes 2 □ No If Yes, Give Year or Dates:			Was Dece If Yes, spe 1 ☐ Yes		Ispanic Ori an, Mexicar Specify:		ecify Yes or No Rican, etc.)		Race - Ameri Black, White, pecify: Wh	etc.
21215-0036	vithin 72 ho sne. :han "natul se Medical	Completed	15. Decedent's E (Specify only highest gr.			(Give life.		ork done d ise retired	ation during mos i) Mech				of Business/Ir	
d 2	e filed v Il Hygie other i vent, th	Be Co	6 years 17. Father's Name (First, Middle, Last	)		ria.	111661	ance	18. Mothe	er's Nam	e (First, Middle			pper
ylar	ould be Menta larked latic ev	ToB	Vasil Madzarac								rvath			
Maryland	nd 2 sh Ith and 27 is m traum		19a. Informant's Name/Relationship ( Paula Keen	Type. Print)  Daughter			_				al Route Numb Balk, Mai			_
Jore,	ages 1 and 2 nt of Health a : If item 27 is or other trau		20a. Method of Disposition 1    Burial 2 □ Cremation 3 □	Removal from State	20b. Place	of Dispo	osition (Na	me of other plac	e)	Febr	uary 2008	20c. Locat	tion - City or T	
Baltimore,	permit. Pa Departme Important any Injury once.	3	4 □ Donation 5 □ Other (Speci 21 Signature of Fungral Service Lice		00	්ද්	2. Name 1	nd Addre	ss of Facili unera	1 Ho	ome Of I	Dundal	k,P.A.	
	<u></u>	7), C	23a. Part1. Enter the disease, of conshock, or heart failure. List only	pplications that caused th	ne death.						Road, I		k,Md.	21222 Approximate Interval Between
	Physician /Medical Examiner	ıer	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as a c	consequence	do 1 ce of):		WIL	n.hs					Onset and Death
Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. De Due to (or as a c		ch cope of):								
P.O. Box (	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	☐ Fetal dea	ath 3[	□Ectopic   □ Other (s		/			230	d. Date of delin	very Day Year
	juires thai signed to lid be deti	by	Part II. Other significant conditions	3	not resulting	g in the u	underlying	cause giv	en in Part I	l. 			contribute to	the cause of death?
Division or Vital Records,	r: The law red icate has been r, page 2 shou	Completed	V	autopsy prior to performed? death?  1 ☐ Yes 2 M No 1 ☐ Ye										opsy findings available ompletion of cause of
ζ	ysicial is certii directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2☑ No	Hospital: 1 ☐ Inpatient	2 🗆 ER/	Outpatie	nt 3∐ D	OA Oth			th <i>(Check only</i> ome 5 ☐ Res		☐Other <i>(Spec</i>	ify)
ou o	Attending Physician: r death. ector: After this certific by the funeral director,	tion: T	27. Manner of Death 1 S Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day )		b. Time o Injury	of M	28c. Injur Wor 1 🗆			28d. Describe			
Divis	To the Hospital or Attending Physician: The lav within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be determined		/ - At home, (Specify)	, farm, st	treet, facto	ry, office			28f. Location City or To	(Street and I wn, State)	Number or Ru	ral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	edical (		hysician: To the best of miner: On the basis of e and manner state	xamination									
	To the within 2 To the Comple	Med	29b. Signature and title of certifier				2	c. Licens	e number				signed (Month	
			) Orange	7.0	,			00	0022	171		C	12/19	108
F	1		30. Name and address of person who	completed cause of dea	th (Item 23	a) (Type,	Print)	fe.	hen	100	Both	~~~	212	24
	Sta Regist		31. Date filed (Month, Day, Year)	32: Registrar'	s Signature	, de	care	9						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** William Cloyd Meyer 17:45 PM 16,2008 February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Manor Care - Rossville Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day Year) March 13, 1934 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 XM 2 ☐ F 73 215-30-3772 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Apt 119 21222 USA 103 Center Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 XNo Specify: <u>6</u> 3 ☐ Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 10 years College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 Is marked other the any injury or other tremman. Plate Mill Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ida Mae Pebley Roy G. Meyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brother 3202 Whiteway Road, Edgemere, Maryland Glendon Meyer 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State February cemetery, crematory or other place)
Belair Memorial Gardens 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Belair, Maryland 20,2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungral Service Licenses Connelly Funeral Home Of Dundalk,P.A. rom 7110 Sollers Point Road, Dundalk, Maryland 21222 23a. Part1. Enter the disease, occumplications that caused the death oo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** emorany /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transi Due to (or as a consequence of) physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably The Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) æ Other: Nursing Home 5 Residence 6 Other (Specify) 1 TYes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 \$ Hospital or Attending Physician: After this s after death. filled in by

death with the Maryland

Baltimore,

within 24 hours at To the Funeral D

State

DHMH 17 Rev 1/2001

Registrar

Medical

Signature and title of certifier

30 Name and address of person

29a. Certifier

(Check only one)

784 adn 32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

and manner stated.

📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

ewood

29c. License number

Kep

29d. Date/signed (Month, Day, Year)

			1- For amend #8 Per	State of Maryland FH G877 370770	d / Depa 8 JH Cer	artment of F rtificate of i	lealth and N Death	lental Hy	giene Reg. No.2	08	04662
Ď.	Physic /Medi		1. Decedent's Name (First, Middle, Alfred Lloyd Mar	Last)				2. Date of De		008	3. Time of Death 7:05 P. M
	Exami		4a. Facility Name (If not institution, I Joseph Richey Ho	give street and number) SPICE			Location of Death		4c. Count	y of Death N/	A
	Funeral Director		218-60-5892	1. Sex 7. Age ( <i>In yrs. le</i> 1. 1	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Jall • 17	th <b>1953</b> y, <u>1955</u>	9. Birthp Cour Balt	place <i>(State or Foreigntry)</i> LIMOYE, MD.
	e Maryland ka-f show tified at	ctor	Usual Residence of Decedent  10a. State 10b. County  iviaryland Harfor		, Town or Loo					1	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	th with th 23a or 28 ist be no	al Dire	10e. Street and Number 625 Burlington C	Court		10f. Zip Code	21040		10g. Citizen of Unite		,
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If the Marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U.S Armed Forces? d 1 ∏Yes 2⊠No If Yes, Give Year or Dates:		Vas Decedent of H f Yes, specify Cuba □ Yes 2 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	- 14. Ra Bla Speci	ce - Americ ack, White, fy: Wh	
21215-0036	l within 72 ho liene, r than "natur the Medical	ompleted	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed)  College (1-4or 5+)  N/A	(Give : life. L	lent's Usual Occup kind of work done o OO NOT use retired Steel WO1	during most of work ()	ing	16b. Kind of E		•
Maryland 2	d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "1 traumatic event, the Med	To Be C	17. Father's Name (First, Middle, La Alfred Lloyd Mar	-			18. Mother's Nam Helena J			,	
	and 2 shousalth and N Salth and N 27 Is ma er trauma		19a. Informant's Name/Relationship Mrs.Kimberly A.								code)296980 ville,S.C.
Baltimore,	t. Pa rtmer rtant		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe  21. Signature of Funeral Service Lice	□Removal from State Ho1	ace of Disposemetery, crem	sition (Name of natory or other place  Mein. Gar	dens Feb			River	,Maryland
Ba	Depar Impol any it		1 Jeffrey	J. jav.	- 1		_			matio and	n Ctr.,P. <i>I</i> 21093
	Physician /Medical Examiner		23a. Pan1 Enter the disease for co show, or heart failure. Ust or Immediate Cause (Final disease or condition resulting in death)	pmplications that caused the death ally one cause on each line.  a. Renal cell (  Due to (or as a consequence)	carcin	er the mode of dyin	g, such as cardiac	or respiratory at	and has	nets	Approximate Interval Between Onset and Death
8760,	be executed ician and burial-transit	al Examiner	Sequentially list conditions, if any, leading to infiltediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence to (or account to (or							
P.O. Box 687	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3□	Ectopic pregnancy Other (specify)				ate of delive	ery Day Year
ds, P	uires that i signed b id be deta		Part II. Other significant conditions		Iting in the un	derlying cause give	en în Part I.	23e. Did to		tribute to th	he cause of death?
or Vital Records,	The law require rate has been sing page 2 should be	Completed by		, 1				24a. Was autop perfo 1 Yes	osv	Were auto prior to condeath? 1 ☐ Yes	opsy findings available mpletion of cause of
Division or Vita	ding Physician: I. After this certific funeral director,	Certification: To Be	25. Was case referred to medical examiner?  1	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury ne, farm, stre	28c. Injun Work M 1 🔲	4 🗆 Nursing Ho	n (Check only o me 5 □ Resid 28d. Describe h	dence 6 🗷 Otl now injury occur	her (Specif rred	THISTICE  WHOSPICE
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only one) (Check only one)	Physician: To the best of my know aminer: On the basis of examinati	/ledge, death	occurred at the tin	ne, date and place, pinion, death occur	and due to the	cause(s) and m	anner as s	rated.
<b>\</b>	To the within 2 To the comple	Medical	29b. Signature and title of certifier	and manner stated.		29c. License	number		29d. Date signe		
	P		30. Name and address of person where RAYMOND W. WILLS		23a) (Type, F	1		BALTI	MORE,	WD.	21204
	Sta Registi		31. Date filed (Month, Day, Year)	32 Registrar's Signat	ure	net !					
DH	MH 17 Bev 1/2		- FEQ T 3	COUNTY STATE OF	2						

4b. City, Town, or Location of Death

Towson

4a. Facility Name (If not institution, give street and number)

Gilchrist

04663

3. Time of Death

4c. County of Death
Baltimore

8:00 р м

/Medical Examiner

	Funeral Director		5. Social Security Number 212-05-1714  Usual Residence of Decedent	6. Sex 1 □ M 2 🛣 F	Age (In yrs. last	Yrs.	If Under 1 Months	Year Days	if Under 24 Hours	Hrs. 8. D Min. Ju	ne 05,	<sup>Year)</sup> 1918	9. Birth Cou Mar	nplace (State or Foreign intry) yland
	e Maryland a-f show iffied at	ctor	10a. State 10b. County Md. Balti	more	10c. City, T	own or Lo								10d. Inside City Limits 1 □Yes 2 □ No
	ath with the 23a or 28 ust be no	ral Dire	10e. Street and Number 1629 Aberdeen					2128				g. Citizen of		USA
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heath and Mental Hygiene. If item 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Marrie 3 XWidowed 4 Divorced	12. Was Deceder Armed Forces d 1 □ Yes 2 □ If Yes, Give Year or Dates	\$? <b>X</b> No	[	Was Deceder if Yes, specify 1 ☐ Yes 2			n? (Specify Puerto Rica	Yes or No- n, etc.)		ck, White	ican Indian, e, etc. White
21215-0036	within 72 ho ene. than "natur he Medical I	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	s Education grade completed)  College (1-40	r 54\	(Give life. L	dent's Usual ( kind of work DO NOT use nas <b>i</b> ng	done di retired)	uring most of	of working	1	6b. Kind of B		cs Company
	ould be filed v I Mental Hygie narked other t natic event, th	To Be Co	17. Father's Name (First, Middle, L French Taylo			1 41 61	1431119			,	st, Middle, M Ckert	aiden Surnar		
, Maryland	1 and 2 should Health and Men em 27 is marke other traumatic	-	19a. Informant's Name/Relationshi		/ Son	1130	Batte	ery	Ave.	Balti	more,	Cify or Town Md. 21	.230	
Baltimore,	Pa ant: ury		20a. Method of Disposition  1 ☐ Burial 2 【X Cremation  4 ☐ Donation 5 ☐ Other (Sp.	ecify)		top S	sition (Name matory or othe Service	e Co	2-	18-08		Towso		
Bal	permit. Pa Departmer Important: any Injury once.		21. Signature of Funeral Service L	1			Name and RUCI 1050	_					04	
	Physician		23a. Part1. Enter the disease, or of shock, or heart failure! List of Immediate Cause (Final disease or condition resulting in death)	complications that causinly one cause on each	ed the death. I		er the mode of		j, such as ca	ardiac or res	spiratory arre	st,		Approximate Interval Between Onset and Death
	/Medical Examiner	er		b	as a consequen	,								1
68760,	ate be executed hysician and the burial-transit	eted by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):											
P.O. Box 68	requires that the death certificate be executed een signed by the attending physician and rould be detached for use as the burial-transit	ıysician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1										ivery Day Year	
ords, P.	quires that in signed by uld be deta	ed by Ph	Part II. Other significant condition	ns contributing to death	but not resultin	7 1	nderlying cau		n in Part I.		23e. Did tob			the cause of death?
Rec	The law ate has b	Complete	-1							_ [	24a. Was an autopsy perform 1□ Yes 2	/	prior to death?	topsy findings available completion of cause of
or Vital	Physiclan: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 inpa		l/Outpatier	nt 3 DOA	Othe	r: 4□ Nursi	sing Home		nce 6 🗷 Ot		city) Hospice
Division or	To the Hospital or Attending Physiclan: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	(Month, I	Day Year) injury - At home etc. (Specify)	injury	М		es 2∐No	0 28f. l		eet and Num		ıral Route Number,
ق	Hospital or 4 hours afte Funeral Dir ely filled in		29a. Certifier  (Check only 2 ☐ Medical E	Physician: To the be xaminer: On the basis	st of my knowle					place, and	due to the ca	use(s) and m		
	To the within 2 To the complet	Medical	29b. Signature and title of certifier	thy like	Stated.	up	29c. 1	icense	number	5	29 E.	d. Date signe	ed (Monti	h, Day, Year) 16, 2008
	b		30. Name and address of person w	who completed cause of	death (Item 23	3a) (Type,	Print)	ha	rles	57.	Bal	70.00	14	16,2008 Zizok
75	Sta	ite	31. Date filed (Month, Day, Year)	32. Regi	strar's Sidnatur	e done	Se de							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year 0930 AM MACK FRANCIS 16 2000 Z /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW MEDICA LENTEL BALTI NO ME N/A If Under 1 Year | If Under 24 Hrs.
Wonths | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) October 02, 1917 5. Social Security Number 7. Age (In yrs. last birthday)
90 Yrs. 9. Birthplace (State or Foreign **Funeral** Days Months 212-07-6681 1 XM 2 ☐ F Mary Land Director Usual Residence of Decedent 10c, City, Town or Location 10a, State 10b. County 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No Baltimore Director Maryland Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2907 Conroy Court Apt B 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Affiled Folces: 1 Tyes 2 No If Yes, Give WWII Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Postal Worker Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Barbara Breneis Frederick J. Mack ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau Francis J. Mack, Jr/Son 9509 -B Horn Avenue Perry Hall Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 2/20/08 Baltimore Maryland 22. Name and Address of Facility Leopard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician HESPIMATONY FAILUME /Medical Due to (or as a consequence of): Examiner PHENMONIA Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner h certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Day Vear 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a Division or Vital Records, P.O. 9□Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has page 2 this certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of After t Certification: 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending Injury within 24 hours after deau.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

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State Registrar M

31. Date filed (Month, Day, Year)

MELISSA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mori-

4940 Eastern

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mathews 12:52 P M Grafton 16 February /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner City Johns Hopkins Hospital Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 16 A 2 F 218-22-1638 129 11929 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at VEN 2 □ No M Director Baltimore 10e. Street and Number 10g. Citizen of What Country? Ave Mossiter 21239 Funeral Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No. If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CHN Sanitation Engineer Baltimore at 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce. ornelius Matthews Lilliau Jefferson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1268 Mossiter Ave Apt 24 Baltimore MD 21239

Date 20c. Location - City or Town, State Bessie Matthews/wite 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Nemorial Park 2122/2008 Baltimore, MI)
22. Name and Address of Facility Vangine C. Greene Funeral Services 4 □ Donation 5 □ Other (Specify) King Memorial Park 21. Signature of Funeral Service Licenses C. Greene Vaught C. Sheere 4905 York Pd Baltimore, N

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4905 York Ad Baltimore, MD 21212 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** 3 days /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisaco of Injury) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the 9 I Inknown 9 Unknown ģ ate has been signed page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an performed? res 2 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

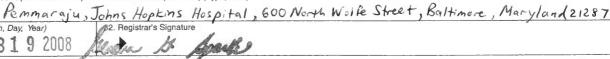
| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) соmpletely and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Medical Doctor RES-000 February 16,2008

State Registrar

9 FEB 1 2008

Vareen 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11-10AM **Physician** ANDREW M0026 February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** NORTHWEST HOSP CENTER RAMOAU STOWN THIORE 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Yrs 19-60-5963 Director Usual Residence of Dece filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 1 Des 2 No Director MDmore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or MOOD Funeral items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian. "natural", or item ledical Examiner ו Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n. any Injury or other traumatic event, the Medic once. College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Pr storlimothy 100 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, Stat 20a. Method of Disposition Marial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dvip shock, or heart failure. List only one cause on each line. Immediate Cause (Final NON-Small Cell **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed g physician and as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical attending plant of for use as IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 Yes 2 No P.O. ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, þ STEVETION 1 ✓ Yes 2 No 3 Probably 4 Unknown been signal Completed DISUZDER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed' certificate 1 Yes 2 No 2 No 25. Was case referred to medical examiner? funeral director. 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day 28b Time of 27. Manner of Death Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation 1 Natural To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 05428 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MORTHER EST (3) Ramalwany

Registrar

31. Date filed (Month, Day,

Year) 0

32. Registrar's Signature

Division or Vital Records. P.O. Box 68760.

		1 - State Registrar		rtificate of De			2008	04667
Physic	ian	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
/Med	ical	Jack Owen Mullholand  4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo	position of Dooth	Feb 8, 2	4c. County of Deat	7:45 P M
Exami	iner	Southern Maryland Hospital		Clinton	ocation of Death		Prince G	
Funeral Director	_	5. Social Security Number 6. Sex 7. Age (In yrs. In 1984 07 3545 1.5 Age (In yrs. In 1984 2□ F 86	last birthday) Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) March 14	9. Birt	hplace (State or Foreign untry)
and w		Usual Residence of Decedent           10a. State         10b. County         10c. City	y, Town or Lo	ocation	-			10d. Inside City Limits
Mary a-f sho ified a	햦	Maryland Prince George's	Te	mple Hills				1 □Yes 2 □ No V X
ith the	Directo	10e. Street and Number		10f. Zip Code		100	g. Citizen of What Co	/1/1
eath w Is 23a must l	eral	4510 Old Branch Ave  11. Marital Status 12. Was Decedent Ever in U.S	Q 13	2074		ocify Vos or No-	United St	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Never Married  1 □ Never Married 2		Was Decedent of Hisp If Yes, specify Cuban,		Rican, etc.)	Black, White	
hours a	d by	****		XX	Specify:			nite
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ntal Hy ed oth	Be	17. Father's Name (First, Middle, Last)		18	8. Mother's Nam	e (First, Middle, Ma	aiden Surname)	
2 should be and Mental is marked or	2	Orval Arthur Mullholand  19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street and	Lilous d Number or Rui	Haywa al Route Number,	rd City or Town, State, 2	Žip Code)
and 2: and 2: n 27 is		Norma Hebekeyser (SISTER)	4413	B Park Place				
Pages 1 nent of He int: If iten		20a. Method of Disposition 20b. PI 1 XNeurial 2 □ Cremation 3 □ Removal from State	lace of Dispo emetery, cre	osition (Name of matory or other place)		Date 20	Oc. Location - City or	Fown, State
nit. Pa artmen ortant: Injury		4 ☐ Donation 5 ☐ Other (Specify) Ced  21. Signatur  of Funeral Service Licensee	ar Hi	11 Cemeters 2. Name and Address	y Feb 15	, 2008	Suitland,	MD
Depai Import	3	I forther moisal		lexandria	Lee	runeral	nome, inc	6633 01d 20735
and the second		23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	n. Do not ent	ter the mode of dying,	such as cardiac	or respiratory arres	it,	Approximate Interval Between Onset and Death
Physician /Medical	_	Immediate Cause (Final disease or condition resulting in death)	Caro	ior Ar	rtho	0,5		Onset and Death
Examiner		Due to (or as a consequ	uence of):			·		
চ ⊭	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	uence of):					
xecute and al-trans	Examiner	Cause (Disease or injury that initiated events c	uence of):					
rificate be executed og physician and as the burial-transit								
ag III	Medical	IF FEMALE:						
The law requires that the death cer the law requires that the death cer the has been signed by the attendir to be should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months?	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
that the de ned by the	hysid	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	outi o c					
res tha igned be det	by P	Part II. Other significant conditions contributing to death but not resu	alting in the u	nderlying cause given	in Part !.		cco use contribute to	
w require been si should b	eted						2 No 3 Pr	
The lav te has age 2	Completed					24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of
	Be C	25. Was case referred to medical example?		2	6. Place of Deat	1  Yes 2 the state of the stat	Mo 1 □ Yes	2□ No
Physic this or	2	1 ☑ Yes 2 ☐ No ☐ ☐ Inpatient 2 ☑	ER/Outpatier 28b. Time o			ome 5 Residen	ce 6 Other (Spe	cify)
E 60 32 2	tion	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation  28a. Date of Injury (Month, Day Year)	Injury	Work?	s 2 No	zou. Describe now	injury occurred	
r Atter er dea irector	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At hou building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,
pital o		29a. Certifier 1 Certifying Physician: To the best of my know	wledge deat	h occurred at the time	date and place	and due to the cau	sca(e) and manner as	stated
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only one)  2 Medical Examiner: On the basis of examinat and manner stated.						
To th Withii To th	Me	29b. Signature and title of certifier		29c. License n			d. Date signed (Mont	· ·
1		While & som			3204		2-10-6	28
6+1		30. Name and address of person who completed cause of death (Item Wendell Pierson. m.D. 7503 Sur	, , , , ,					
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signat	ture	Koad, Cli	nton, M	20735		
Regist	rar	FEB 1 9 2008 Asses &	2042	7				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ State State Amend 5&10e, perFh, g876, 2/29/08 TT Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Dolores A. Muffoletto Feb 2008 10:00p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Riverview Nursing Center Essex Baltimore Hours Min. Oct. 2, 1924 Birthplace (State or Foreign Country) If Under 1 Year Months Days 5. Social Security Number 219-<del>19-</del>7612 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 M 2 K 83 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 23a or 28a-f show ust be notified at 1 ☐ Yes 2 X No MD Baltimore Completed by Funeral Director Essex 10e. Street and Number Livey
1631 Teurkey Point Road 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a any injury or other traumatic event, the Medical Examinationals once. 21221 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker own home 9th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Albert Fischer Maria Herotek ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita McCann /daughter Turkey Point Road Baltimore MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Most Holy Redeemer 2/15/08 Baltimore MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Baltimore MD 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Connelly Funeral Home of Essex 21221 Approximate
Interval Between
Onset and Death
Lun - Kurum Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. East Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Year Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 21☐ No 3 ☐ Probably 4 🗂 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year)
02-13-2008 29b. Signature and title of certifier MD BASTERN BLVD. M.D-21221 and address of person who completed cause of death (Item 23a) (Type, Print) WASEEM. 09

Registrar

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2008 8:00 Dona Gene Mann Feb. 15, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson
If Under 1 Year | If Under 24 Hrs. Baltimore Gilchrist Hospice Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2X F 78 Director March 6, 1929 Maryland 215-24-9367 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 X No Director Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be r 21286 532 Goucher Blvd USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White Specify 2 3 Widowed 4 Divorced r than "natur the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 N/A other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If iten Z7 is marked oth any linjury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be Vernon Taylor Elizabeth Hallowell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael T. Mann/Son 307 West Chesapeake Towson, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 19, 2008 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 Bryan W. Clary Approximate Interval Between Onset and Death 23a. Part1. Enter the distar shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only on cause on each lin Immediate Cause (Final disease or condition resulting in death) Physician day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending ph IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 Live birth 2 | Fetal death in the past 12 menths? 1 ☐ Yes 2 ☑ No Day Month Vear 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2₽ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate has irector, page 2 1□ Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 임 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: stipped on ice outside her residence Injury 1 Natural 5 Pending investigation 9:00 AM 1 ☐ Yes 2 ☑ No February 13,2008 2 Accident while getting The morning Newspaper 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (5 reet and Number or Rural Route Number, City or Town, State) 4 Homicide determined 532 Goucher Blud Towson, MD 2128 tome Hospital 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Division or Vital Records, P.O. Box 68760 within 24 hours a

To the Funeral I

completely filled To the

10 State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of contifier

31. Date filed (Month, Day, Year)



29c. License number

5205

29d. Date signed (Month, Day, Year)

February 16, 2008

		ļ	For State Registrar	State of	Maryland / Dep	artment of		nd Me		0 /	200	01.0	- 76
	-	-1	Registrar     Decedent's Name (First, Middle, Last	t)		Timodio oi	Death	2.	. Date of De	Reg. No.	JUÖ	3. Time of	Death
*	Physic		Anna K. Mitchell						Month 2	Day 13	Year 2008	11:15	ΡМ
4000	/Medi Examii		4a. Facility Name (If not institution, give		nber)	4b. City, Town,	or Location of	Death	_		ty of Death		
			Genesis Elder Car	e		Severna				Anne	Arun	de1	
100	Funeral		5. Social Security Number 6. S	ex □ M 2 <b>XX</b> F	7. Age (In yrs. last birthday	If Under 1 Yea   Months   Days		4 Hrs. 8. Min.	Date of Birl (Month, Da	y, Year)	9. Birth	place (State or	<sup>r</sup> Foreign
A. T.	Director		212-10-2630 1  Usual Residence of Decedent		97 Yrs.	<u> </u>		F	eb. 4,	1911		MD	
	land ow		10a. State 10b. County		10c. City, Town or L	ocation						10d. Inside Cit	y Limits
	Mary r-f sh fied a	ţo	MD Anne Arı	ındel	Glen Burn	ie						1 ☐ Yes	XXNo
	or 282	Funeral Director	10e. Street and Number			10f. Zip Code				10g. Citizen of	f What Cou	intry?	
	23a ust b	la	50 Forestdale Ave			21061				USA			
	tems	nue	11. Marital Status	Armed For	dent Ever in U.S. 13. rces?	Was Decedent of If Yes, specify Cu	Hispanic Origi Iban, Mexican,	in? (Specif Puerto Ric	y Yes or No can, etc.)	- 14. Ra Bl	ace - Ameri ack, White	can Indian, , etc.	
36	s afte		1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Giv Year or Da	e	1 ☐ Yes 2 🛣 No	o Specify:			Spec	ify: Wh	ite	
21215-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	Completed by	15. Decedent's Ed		16a. Dece	edent's Usual Occ	upation			16b. Kind of			
115	within 72 iene. than "na he Medio	plet	(Specify only highest gra	de completed) College (1	(Give	e kind of work don DO NOT use retir	e during most ( red)	of working	- 1			,	
212	d with giene er tha	ĕ	8	- College (1	Homem	aker				Own He	ome		
	should be filed within 72 hours after death with the Marylar ad Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 25a be notified at imatic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)				18. Mother	's Name <i>(F</i>	First, Middle,	Maiden Surna	ame)		
yla	should be ind Mental s marked o	၉	Frank Fried					Babu					
Maryland	l 2 sho h and ls ma		19a. Informant's Name/Relationship (7			ing Address (Stree						p Code)	
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Ms. Margaret Dish	man/Dau	ghter 232 20b. Place of Disp	Wicklow .	Ave., (	Glen 1		20c. Location		own State	
Baltimore,	0 0		1 X Burial 2 ☐ Cremation 3 ☐		State cemetery, cre	ematory or other p	116	eb. 18	8,		,		
Ħ	+ + # = =		4 □ Donation 5 □ Other (Specify  21. Signature of Fulleral Service Licen		Holy Cro	ss Cemet 2. Name and Add	ery ress of Facility	2008	loton	Glen Bu	urnie	, MD	
Ba	permi Depar Impor any Ir		V/W	>		2nd Ave							rices
i i	12-16		23a. Part . Enter the lisease, or compshock, or heart failure. List only	olications that ca						-	1001	Approximate Interval Betv	
de	Physician		Immediate Cause (Final	one cause on e	YO Sep su	<u>.</u>						Onset and D	veen Death
7	/Medical		disease or condition resulting in death)	a	or as a consequence of):								
1	Examiner		Cognentially list conditions	h D	emerita	21							
/	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (	or as a consequence of):								
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	or as a consequence of):								
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ical E		Due to (	or as a consequence or).								
687	phys phys s the			d									
Box (	death certifica attending phi i for use as th	Physician/Med	IF FEMALE; 23b. Was decedent pregnant		come pf pregnancy					23d. D	ate of deliv	/erv	
	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Pregn	ant at time of death 5	⊒Ectopic pregnar □ Other <i>(specify)</i>	icy				Month	-	ear/
P.0	at the de by the a tached	hys	9 ☐ Unknown	9□Unkno	own								
	res that igned be be det	by P	Part II. Other significant conditions of	ontributing to de	eath but not resulting in the	underlying cause g	given in Part I.		23e. Did to	obacco use co		the cause of de	eath?
ord	w require been sis								1 🗆 '	Yes 2⊠No	3 🗌 Pro	bably 4 🔲 U	nknown
Records,	law r las be	Completed							24a. Was	osy		opsy findings a	
E		Con							perfo 1∐ Yes	rmed?	death? 1 ☐ Yes	20 No	
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			41		Check only o			`	
or	di S	<b>P</b>	1 Yes 2X No 27. Manner of Death	Hospital: 1 ☐ I	npatient 2 ER/Outpatient 28b. Time	III 3 DOA				dence 6 0		ify)	
u	ing Affer une	ion	1 Natural 5 ☐ Pending		h, Day Year) Injury	W	ork? □Yes 2□N		a. Describe i	how injury occi	urrea		
Division	I or Attending after death. Director: After in by the funer	fical	3 Suicide 6 Could not be	Zoe. Place	of injury - At home, farm, st				. Location (S	Street and Nun	nber or Ru	ral Route Numi	ber,
Ο̈́	al or A after i Direction by	Certification:	4 Homicide determined	buildir	ng, etc. (Specify)				City or To	vn, State)			
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in b		29a. Certifier (Check only 2 Medical Exam	ysician: To the	best of my knowledge, dea	th occurred at the	time, date and	d place, and	d due to the	cause(s) and r	manner as	stated.	,
	To the He within 24 To the Fe complete	Medical	one)	and manr	ner stated.			occurred	at the time,				,
	Nith Too	Σ	29b. Signature and title of certifier		- 017		nse number	a 1		29d. Date sign	ned (Month	, Day, Year)	-00
			Mens	m	2 100		515	96		rebru	ary 1	4"21	2018
	6		30. Name and address of person who		e of death (Item 23a) (Type	Print) Kwood	Roman	1 10	3 1	len R	OKNI	MD.	2106
	Sta	ate	31. Date filed (Month, Day, Year)	(VICEY	gistrar's Signature	-	11000	1	2, 0	(1-7/6)	UV TIL	100	2100
	Regist			2008	gistrar's Signatur								

State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 7 per fh 98/6 2-19-08 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No.2 U U 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 13, 2008 February 3:43 A. M Hansen Mack /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 11021 Fawsett Road Montgomery Potomac If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖾 F 78 April 12, 1929 Director 577-42-3259 New York Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Indialantic Florida Brevard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 32903 United States 314 Cocoa Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 Married 'natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify: 9 3 ☐ Widowed 4 ☐ Divorced al Hygiene. I other than "natura vent, the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be if Health and Menta item 27 is marked Paul Hansen Ragnhildt Mina Margarete Berg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Mack - Husband 314 Cocoa Avenue, Indialantic, Florida 32903 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 'Department of H Important: If ite any injury or ot February 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial Park 16, 2008 Rockville, Maryland
22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave.
Bethesda, Maryland 20814 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 21. Signature of Funeral Service Licensee M01473 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Glioblastoma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine certificate be executed Cause (Disease or injury that initiated events resulting in death) Last ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒No 2 Fetal death 3 □Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Tes 2 No 3 Probably 4 Munknown as been si 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy certificate has 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Residence 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 filled in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 X Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No al or Attencate after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. To the 29b. Signat re and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) Vanca. Wrollewsk mi

State Registrar

30. Mame and address of person who completed cause of death (Item 23a) (Type, Print)

Genevieve Ann Wroblewski

31. Date filed (Month, Day, Year)

M.D.

rar's Signatu

D0064615

1355 Piccard Drive, Ste 100, Rockville, MD 20850

February 13, 2008

			1 - State Registrar			Certifica	ate of	Death		Reg. N	10. ZUL	d	046/2	
	Physic	ion	1. Decedent's Name (First, Middle, La	ast)					2. Date of D Month		ay Ye	ear	3. Time of Death	
	/Medi		Rob	ert Charle	s Muhlba	ch			Februa	ry 1	16, 200	)8_	9:50 A <sup>™</sup>	
	Examir	ner	4a. Facility Name (If not institution, gi			4b. Ci		r Location of Dea	th	١.	c. County of I			
16.		4	Shady Grove Adve		ital le (In yrs. last birt	hday) If Unc	Roc	k <b>vill</b> e If Under 24 Hrs	8. Date of B		Montgor			
**	Funeral Director			1 【X M 2 ☐ F		/rs. Month		Hours Min		lay, Yea.	r)	Coun	ace (State or Foreign try) York	
	/land ow at		10a. State 10b. County		10c. City, Town	or Location						10	Od. Inside City Limits	
	the Man 28a-f sh notified	Funeral Director	Maryland Montgon	nery			kvil	le		10a. C	citizen of Wha	t Coun	1 Mary Yes 2 □ No	
	n with	al Di	1032 Grandin Ave	nue				0851			nited S			
	death	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Dec		lispanic Origin? (San, Mexican, Pue	Specity Yes or N		14. Race -	America	an Indian,	
215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 271s marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 If Yes, Give Year or Dates:	No		2 <b>K</b> ) No	Specify:	to riican, etc.)		Black, \ Specify:		nite	
5-6	"natu	ete	15. Decedent's E (Specify only highest gi	ducation rade completed)	16a.	Decedent's U: (Give kind of the	work done	ation during most of wo d)	orking	16b.	Kind of Busin	ess/Ind	ustry	
121	within lene. than the Me	Completed	Elementary/Secondary (0-12)	College (1-4or !		Owner	use retired	1)		Loc	k & Sa	afe	Company	
d 21	filed Hygid		17. Father's Name (First, Middle, Las	t)				18. Mother's Na	me (First, Middl				Company	
au	ld be ental ked o	To Be	Louis Muhlbach	•					ence Hil		,			
Maryland	should be fand Mental I	-	19a. Informant's Name/Relationship	(Type. Print)	19b.	Mailing Addre	ess (Street	and Number or F			or Town, Sta	te, Zip	Code)	
	1 and 2 sho Health and I tem 27 Is ma other trauma		Stephen R. Muhlb	ach/Son	66	01 Eid	er Co	urt Fre	ederick,	Mar	vland	217	03	
ore,	es 1 a of He fitem		20a. Method of Disposition		20b. Place of	Disposition (A	ame of	1 - 1	Date 22,	20c. I	Location - Cit	y or To	wn, State	
altimore,	Pages ment of I		1 <b>∑</b> Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other ( <i>Sp</i> ec		Quanti	co Nat terv	ionai		2008	Tri	iangle.	Vi	rginia	
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lice	ensee	M00198	Rober 300 We	t <sup>nd</sup> A <sup>ddre</sup> st Mor	Pumphrey	Funera	1 Ho	ome/Roc	kvi MD 2	11e, Inc. 20850-2805	
	e k		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused	the death. Do n								Approximate Interval Between	
1	Physician		Immediate Cause (Final disease or condition		mall Cel	1 Lung	Canc	er					Onset and Death	
	/Medical		resulting in death)	_ u	a consequence o							_		
1	Examiner	_	Sequentially list conditions,	b		0								
,	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence o	1):								
1	xecut and al-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence o	f);						+		
68760,	icate be executed physician and s the burial-transit			· ·	·	,								
687	fficate g phys	Medical												
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and tape 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 □Ectopic 5 □ Other		1			23d. Date o Month		ry Day Year	
Δ.	that led by deta		Part II. Other significant conditions	contributing to death b	ut not resulting in	the underlying	cause giv	en in Part I.	23e. Did	tobacco	use contribu	te to th	e cause of death?	
ords	w requires been sign should be	ted by			1	Yes :	2  No 3[	] Prob	ably 4 ₩Unknown					
or Vital Records,		Completed				24a. W <i>a</i> auto per 1∐ Yes	s an opsy formed? 2 🔯 N	dea	th?	osy findings available inpletion of cause of				
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth		ath (Check only	one)				
0	Phys this al dir	은	1 ☐ Yes 2 No  27. Manner of Death	28a. Date of Inju				4 □ Nursing	Home 5 ☐ Res			Specify	"	
O	ing Affer une	tion	1 X Natural 5 ☐ Pending	(Month, Da	y Year) Ir	jury M	28c. Injur Worl	k? Yes 2 □ No	20d. Describe	HOW HIJ	ary occurred			
Division	il or Attending after death. I Director: After d in by the funer	fica	3 Suicide 6 Could not b	28e. Place of inj	ury - At home, far				28f. Location	(Street a	and Number o	r Rurai	Route Number,	
Ö	al or after all Direction bill Direction bill bill bill bill bill bill bill bil	Certification:	4 ☐ Homicide determined	building, et	c. (Specify)				City or To	own, Sta	ite)			
	To the Hospital or Att. within 24 hours after de To the Funeral Direct. completely filled in by the	edical (	29a. Certifier (Check only one)	hysician: To the best miner: On the basis o and manner st	f examination and	death occurre Vor investigati	ed at the tir	ne, date and place ppinion, death occ	e, and due to the	e cause( e, date a	(s) and manne nd place, and	er as st	ated. the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of cortifier			2	9c. Licens	e number		29d. D	ate signed (A	Nonth, I	Day, Year)	
			M Almil	102	1657	1	2	1161	08					
	11/1		30. Name and address of person who Irving Mizus, M.		eath (Item 23a) (Concord	Type, Print) Street				Mary	land 2	089	5	
Şe,	Sta Registi	ite rar	31. Date filed (Month, Day, Year)	rving Mizus, M.D. 10605 Concord Street, #500, Kensington, Maryland 20895  Date filed (Month, Day, Year) FEB 1 9 2008 Registrar's Signature										

DHMH 17 Rev 1/2001

08-01311 Shenera Norris Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

henera Norris		State of Maryland / Department of Health and Mental Hygiene  1- For State  Certificate of Death  Reg. No.  2008	467
Physiciar		1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of De	
Medical Examin		5 nenera / 10 rris February 15, 2008 0917 1113	3
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  4d. County of Death  Baltimore	
Funeral	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State	or
Director		216-88-0390 1 M 2 F 3/ Yrs. Months Days Hours Will. 11-15-1976 Country) PY	19.
, uny	_	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside C	ity Limits
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Maryland 288-f sho d at once	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
ith the M 23a or 2 notified	ᅙ	4409 Fair View Ave 21216 USA  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, BI	ack.
eath w items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bi White, etc.	K
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036 ithin 7. re. r than Ledical	Completed	10th NIA House Keeper Homes	,
D 212: should be and Menta 7 is marko	e le	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
MD d 2 shc lth and n 27 is aumati	1	Rose 1. Green wood - mother 34 N. morky St. 13alto, md, 212	29
Ore, es l an of Hea If itel		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, July 20c. Location - City or Town, State crematory or other place)  KING MEM. Park 2-23-08  Rand all Stown	7 220
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other tr	-	4 Bollegion 5 Other Specify	ינוייון.
Balti permit. Departn Imports injury o	1	Sport 1 Wind 240 Fredhilfon fass baltimore MD 212	
Physician  # /Medical	T	23a/ Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximately the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	
xaminer	Ì	Immediate Cause (Final disease or condition resulting in death)  a Multiple Sharp Force Injuries  a Multiple Sharp Force Injuries  Due to (or as a consequence of):	auı
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led lisit	Exa	events resulting in death) Last  Due to (or as a consequence of):  d.	
50, te be executed tysician and e burial - transit	ledical	UNPENDED AMENDED	
760, ficate be g physici the buri	Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day	Year
Box 68760 death certificate be the attending physical for use as the bu	Physician/M	past 12 months?    1   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   Day	, ou
D. Bo t the deat by the at ached for	hys	1 Yes 2 No 9 ✓ Unknown g Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of	death?
P.O.	ক্র	1 Yes 2 ✓ No 3 Probably 4	Unknown
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n of Vii ling Physi After this funeral dir	의	27 Manner of Death 28a Date of Injury 28b. Time of Injury 128c. Injury at Work? 28d. Describe how injury occurred	
	틽	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury Feb 15, 2008  28b. Time of Injury 0859 hrs  28c. Injury at Work? 1 Yes 2 No  28d. Describe how injury occurred Subject assaulted	
Division tal or Attendi rs after death. al Director: A	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Multi-Family Apt.  28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Numbe	ımber, City
To the 14 within 24 To the F complete	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
FSER	ğ		ir)
		O.C.M.E. February 16, 2008	
2	I	30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Sta	-	31. Date filed (Month, Day, Year) 32, Registrar's Signature	
Registr	ar	FEB 1 9 2008 (12)	

			Please Type or Print in Black Indelible Ink. Ensure All	•	
		_	1 - State of Maryland / Department of Health and Me Certificate of Death	ental Hygier Reg. 1	2000 04014
	Physici /Medic		Tarrille		Day Year 1:30 A <sup>M</sup>
	Examin Funeral Director		Months Days Hours Min.	3. Date of Birth (Month, Day, Yea Aug. 3,1	
	ne Maryland 8a-f show ptified at	Director	Usual Residence of Decedent  10a. State		10d. Inside City Limits 1 □ Yes 2 ♣ No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mentall Hygiene. At Hem 27 is marked other than "natural", or items 23a or 28a-f show withen 21s marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral Dir	10e. Street and Number 7425 Blevins Avenue  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specifityes, specify Cuban, Mexican, Puerto Ri	Un	ited States  14. Race - American Indian, Black, White, etc.
215-0036	2 hours afte latural", or it ical Examin	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:  15 Decedent's Education 16a. Decedent's Usual Occupation	16b.	Specify: White Kind of Business/Industry
2121	filed within 7 Hygiene. ther than "n ent, the Medi	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) 10 Years  (Give kind of work done during most of working life. DO NOT use retired)  Heating & Air Conditio  17. Father's Name (First, Middle, Last)	ning 1	R. E. Michel
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, the Mec	To Be	Frank L. Neville Mab	le Abbor	t
Ministra .	s 1 and 2 s if Health ar item 27 is other trau		Gloria Ruby Sturner (Sister) 7425 Blevins Ave. Ed		Maryland 21219  Location - City or Town, State
Baltimore,	permit. Pages Department of I Important: If Ite any injury or of once.		4 Dopation Dother (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility		altimore, Maryland
8	S S E E S		Duda-Ruck Funeral H. 7922 Wise Ave. Dun  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	dalk, Ma:	ryland 21222  Approximate Interval Between Onset and Death
	The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires that the law requires the law	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	rary	Clisease
.O. Box 6	that the death certificated by the attending properties as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ Unknown		23d. Date of delivery Month Day Year
Records, P.	w requires that been signed to should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
		Completed	<u> </u>	24a. Was an autopsy performed 1☐ Yes 2 ☑	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
Vital	Physician: r this certifica ral director, I	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA  Other: 4 ☐ Nursing Hom		
	ling Phy After this funeral d	ation: To	I Impatient 2 ENOutpatient 3 BOX 4 Nursing Hom	e 5 Residence 8d. Describe how in	e 6 □Other (Specify) njury occurred
Division	or The Pire	Certification:	4 Homicide building, etc. (Specify)	City or Town, S	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier  (Check only one)  1 ☐ Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, at (Check only one)  1 ☐ Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, at (Check only one)  2 ☐ Medical ExamIner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.  29b. Signature and title of pertifier  29c. License number	ed at the time, date	and place, and due to the cause(s)
	2		Match MD D56466	2	Date signed (Month, Day, Year)
	Sta	ate	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SWATT PHATAK 4924 Compbell B(vd)  31. Date filed (Month. Day, Year) 32. Begistrar's Signature	white	Morsh MD 21236
DHI	Regist	rar	FEB 1 9 2008 Read & Specific		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** NASSAR EAN February 16 13:22 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Johns Hopkins Bayriew Medical Center Baltimore N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 12-01-1928 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Séu **Funeral** 1 M 2 TF Months New York 083-22-2813 79 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show iry or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director Virginia Arlington Arlington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2003 Colombia Pike #423 22204 Funeral U.S.A.

14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Completed by 3 Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Sales Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Daniel Otiaviano Catherine Anna

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) David F. Nassar - Son 2600 13th Road South #388 Arlington, VA 22204 of Disposition (Name of Date 20c. Eccation - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department o important: If any injury or Metropolitam Crematory 02/19/2008 Alexandria, 21. Sign of Funeral Service Licens 22. Name and Address of Facility 5305 Harford Road Baltimore, Maryland 21214 Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear dailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory **Physician** 20 minutes /Medical Due to (or a a consequence of Examiner Ischemia hours Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as attending properties for use as 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9□Unknown 9 ☐ Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24a. Was an autopsy performed? 1∐ Yes 2 1 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 : certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif RES-000 February 16. 2008 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Prashanth Vallabhajos yula M.D. 4940 Eastern Avenue, Baltimore

Registrar

State

31. Date filed (Month, Day, Year)

32. gistrar's Signature

2008

MALK MORRIS

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2008 01676

JNK UNK		State of Maryland / Departmen - For State Certificate			na ivient	aı Hyg		eg. No.	200	0 0407		
Physicia	n/	Registrar  1. Decedent's Name (First, Middle,Last)		-			Date of Dea	th	Year	3. Time of Death		
al Examin		Marc R. Norris					Month February			0621 hrs		
		4a. Facility Name (if not institution, give street and number) 9325 Presbyterian Circle	1	City, Town, o		f Death		4c. County of Death  Howard				
Funeral	4	Social Security Number 6. Sex 7. Age (In yrs. last birthda	ay)	If Under 1 Ye	ear If Unde	r 24Hrs.	8. Date of Bi	rth(MM/DD/	YYYY) 9. Bir	thplace (State or		
Director	-	217-92-9130 1XM 2 F 33	Yrs.	Months Da	ays Hours	Min.	Feb	13, 19	974 Foreig	District of Columbia		
	İ	Usual Residence of Decedent								10d. Inside City Limits		
w any		10a. State 10b. County 10c. City, Town or I								1 Yes 2 X No		
Aaryland 28a-f show 1 at once.	힑	Maryland Baltimore Catonsville  10e. Street and Number 10f. Zip Code								intry?		
or 282	Director	3 Island Run Court			21228		ļ		USA			
with th			3. Was I	Decedent of I	lispanic Onc	gin? ( Spe	cify Yes or N	0- 14.	Race - Amer	rican Indian, Black,		
death ritem	Funeral	1 X Never Married 2 Married Armed Forces?  1 Yes 2 X No		, specify Cub			ican, etc.)		White, etc.	. 1		
after affer on iner n	Ď.	3 Widowed 4 Divorced If Yes, Give Year or Dates:		es 2X			1 1	1	ecify: Whi			
hours 'natur	g l			Usual Occup t of working li				160. Kind	of Business	midustry		
136 hin 72 e. than than	릵	12	Bar	ber				Self	Empl	oved		
215-0036 be filed within 7 mal Hygiene. rked other than ent, the Medica	Completed	17. Father's Name (First, Middle, Last)						Maiden Sur				
121 The fill ental F arked vent, g	8	Lawrence D. Norris		Address (Str		Bet	tte Gl	aze	Tourn Ctat	o Zin Codo)		
D 21 should I and Mer 7 is mar	의									nd 21228		
e, MD and 2 sho lealth and item 27 is traumati	ŀ	20a. Method of Disposition 20b. Place of D	Dispositio	on (Name of		t car	Date			r Town, State		
nore ages 1 nt of H rt: If	١	1 Burial 2 X Cremation 3 Removal from State crematory 4 Donation 5 Other Specify:			Inc	02/2	L8/08	Balt	imore	, Maryland		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	1	21. Signature of Funeral Service Licensee	22. Na	me and Addre	ess of Facilit	y Maci	Vabb F	uneral	Home	P.A.		
		Thomas Gregory	30	1 Fred	lerick	Road	d Cato	nsvill	Le, Ma:	ryland 21228		
Physician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not e failure. List only one cause on each line.	enter the	mode of dyir	ng, such as o	cardiac or	respiratory a	rrest, snock,	or neart	Approximate Interval Between Onset and Death		
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	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause						·				
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Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	J/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 1 live birth	_	al death		ic pregnar	ncy		Date of delive onth	ery Day Year		
X 68	Physician/N	past 12 months?  4 Pregnant at time of death 5	=	er (Specify)								
	hys	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting it	in the un	derlying caus	se given in P	Part I	23e. Did	tobacco us	e contribute	to the cause of death?		
Division of Vital Records, P.O. B pital or Attending Physician: The law requires that the d ours after death.  neral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached	ρ	Part II. Other significant conditions Community to death but not resource	iii die dii	idenying code	oc given iii i					obably 4 Vnknown		
ds, equire	ompleted						24a. Wa			autopsy findings available o completion of cause of		
COF e law i e has b	mp						per	opsy formed? s 2 No	death?	, .		
II Re	ပ	25. Was case referred to medical		26.PI	ace of Death	(Check o						
Vita ysicia his cel	o Be	examiner?	tpatient	3 DOA	Other <sub>4</sub>		Home 5		e 6 🗸 Oth	ner: Scene		
of 'Affer I	n:T	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Ti	ime of Inj	′′	Injury at Wor		28d. Describ	e how injury	occurred			
sion trend: death. ctor:	atio	1 Natural 5 Pending Prod 2/11/2008 FNd 6	6:18	am j	Yes 2 X		n (Street and Number or Rural Route Number, City State)					
Divis al or A s after I Dire	Certification:	3 Suicide 6 X Could not be determined (Specify) Church she			ce bullaing, e	etc.	or Town	, State)	rian Cir	MD Ellicott City		
Divis Hospital or A 24 hours after Funeral Dire		29a. Certifier 1 Certifying Physician: To the best of my knowledge death	h occurr	ed at the time	e, date and p	lace, and	due to the ca	use(s) and	manner as si	ated.		
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invariant manner stated.	vestigatio	on, in my opir	nion, death o	occurred a	t the time, da	te and place	e, and due to	the cause(s)		
with Co.	Me	and manner stated.  29b. Signature and title of certifier		29c. Lic	ense numbe	r				Month, Day, Year)		
		aux 2		0.	.C.M.E.			Febru	ıary 12, 2	008		
		30. Name and address of person who completed cause of death (Item 23a)		troot Deli	imoro Mr	3 24204						
			enn Si	treet, Balti	imore, ML	120						
St	ate		0249									

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			1. Decedent's Name (First, Middle, Las	()				eath		3. Time of Death			
	Physici /Medi		Nam Nguyen						Febru	ary	4, 2008	11:19 AM	
1	Examir		4a. Facility Name (If not institution, give	street and number)		4	lb. City, Town, o	or Location of Dea	ıth	40	. County of Deat	h	
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	Funeral Director		197-00-9130	X 7. Ag XM 2□F	e (In yrs. last birt 76		If Under 1 Year Months Days	If Under 24 Hr Hours Mir		irth ay, <i>Year</i> 193	9. Birt Co 32 Vie	hplace (State or Foreign untry) tnam	
	and *		Usual Residence of Decedent  10a. State 10b. County	· · · · · · · · · · · · · · · · · · ·	10c. City, Town	or Local	tion					t0d. Inside City Limits	
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	or 28a-f	ect	MD Montgome  10e. Street and Number	ry	De	thes	10f. Zip Code			10a C	tizen of What Co	21	
	ath with	Funeral Director	4521 East West Hi				20	)814			USA		
980	72 hours effer death with the Maryland naturel', or items 23a or 28a-f show dical Examinar must be notified at	by	11. Marital Status unk  1 Never Married 2 Married  3 Widowed 4 Divorced	1 ☐ Yes 21X No			is Decedent of Nes, specify Cub	dispanic Origin? ( an, Mexican, Pue Specity:	Specify Yes or N rto Rican, etc.)	10-	14. Race - Ame Black, Whit Specify: W		
Maryland 21215-0036	c • 3	Be Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) unk	nt's Usual Occup nd of work done NOT use retire	oation during most of w d)	unk orking	16b. I	(ind of Business/	ess/Industry unk				
9	filed Hygi Sther	ပိ	17. Father's Name (First, Middle, Last)					18. Mother's N	me (First, Middl	e, Maidei	n Sumame)		
an	d be ental		Thien Pham						i Nguyer		,		
₹	shoul mark	၉	19a. Informant's Name/Relationship (7	vpe. Print)	19b.	Mailing	Address (Street	and Number or I			or Town, State, 2	Zip Code)	
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Baltimore,	nit. Pages 1 and 2 should be filed within carternent of Heelth and Mental Hyglene, ortent; if item 27 is marked other then injury or other treumatic event, Iram.		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Mother (Specify	Removal from State	20b. Place of cemeter	Dispositi		COLUMN TO SERVICE	Date		ocation - City or	Town, State	
Balt	permit. Page Dapartment of Importent: if any injury or 2002.		21. Signature of Funeral Service Licen-	Wade, Dir	ctor		te Anat timore,	omy Boar		. Ва	Ltimore	Street	
	Physician /Medical Examiner	16	23a. Part . Enter the disease, or empshod for heart failure. List only of the disease or condition resulting in death)  Sequentially list conditions, if any leaders to importate.	a	enatore a consequence of	ot enter i	the mode of dy	ng, such as cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death	
68760,	eath certificate be executed ettending physician end for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequence (	of):							
P.O. Box 6	death a etter id for u	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death		ctopic pregnanc hther (specify) _	у			23d. Date of del Month	ivery Day Year	
	iaw requires that the de es been signed by the e 2 should be deteched f	ed by PI	Part II. Other significant conditions of				the cause of death?						
of Vital Records,	The ate h pege	Completed by							24a. Wa aut per 1 □ Yes	opsy formed?	prior to death?	itopsy findings available completion of cause of	
ita	Physician: rthis certific ral director,	Be (	25. Was case referred to medical examiner?					26. Place of D	ath (Check only				
Ž	hysic his co	ဥ	1 ☐ Yes 2 ₺No	Hospital: 1   Inpatie	ent 2 ER/Ou	patient	3□ DOA Ott	er: 4 🗌 Nursing	Home 5 PRe	sidence	6 ☐Other (Spe	cify)	
Division o	To the Hospitel or Attanding Physicien: within 24 hours effer death. To the Funeral Director: Affer this certific completely filled in by the funeral director.	Certification:	27. Manner of Death  1 L Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be	28a. Date of Inju (Month, Da		ime of njury	M 1		28d. Describe	how inju	iry occurred		
Divi	pitel or At ours efter o erai Dirac filled in by		4 Homicide determined	building, et	c. (Specify)			- devi-	City or T	own, Stai	e)	ural Route Number,	
	To the Hospitel within 24 hours of the Funeral completely filled	Medicai	(Check only one)	rsician: To the best iner: On the basis o and manner st	fexamination and	death of Vor inves	ccurred at the ti stigation, in my o	me, date and place opinion, death oc-	e, and due to the curred at the time	e cause(: e, date ar	s) and manner as ad place, and due	to the cause(s)	
	To th To th comp	Me	29b. Signature and title of certifier				29c. Licens			29d. D	ate signed (Mont		
			Ma	lhen			Do	323429	7		2/8/0	28	

State Registrar

FEB 1 9 2008 DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TON THAT CHIEW, MD

31. Date filed (Month, Day, Year)

32. Registrar's Sign

32. Ragistrar's Signature

ORIGINAL

7505 New Harphore Ne # 310 Takana Parke, MD 20910

C	8-01	293
í	inda	Nelson

inda Nelson		- For State	St	ate o	of Maryland /	•	tment of l ificate of l		d Ment	al Hygiene		. No. 20	0.8	0467		
Physician/	Physician/ 1. Decedent's Name (First, Middle,Last)  Linda Nelson									2. Date o Month	f Death		3.	Time of Death 1120 hrs		
wedicai Examine		Linda Nelson  Month Day Year February 14, 2008  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death									eath	11201115				
		St. Agnes H						Baltimore								
Funeral Director		5. Social Security No. 218–62–949	96	6. Sex	x 7. Age	e (In yrs. las		Months Day		Min.		(MM/DD/YYYY) 9. Fo , 1955	Birthpl reign Count			
any	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location										10	Od. Inside City Limits				
Stand land frshow		MD		В	altimore			Catonso	i11e					Yes 2 No		
r death with the Maryland or items 23a or 28a-f show must be notified at once.		10e. Street and Nun		eet					21228			g. Citizen of What C	SA			
<u>ال</u> اء قر		11. Marital Status  1 Never Marrie  3 Widowed			12. Was Decedent Armed Forces?  1 Yes 2  If Yes, Give Year	X No	If Yes		n, Mexican,	in? ( Specify Yes Puerto Rican, etc		African	C.	n Indian, Black, erican		
hours aft natural' Ex ming	2 -		ucation (Spe	cify on	ly highest grade com		16a. Decedent's		tion (Give k	kind of work done use retired)		16b. Kind of Busine	ss/Ind	ustry		
5-0036 ed within 72 hour hygiene. other than "natu the Medical Ex in Completed	1	Elementary/Seco			College (1-4 or 5	5+)		ısekeeoin				Social Sec	urit	y Adm.		
e, MD 21215-0036  I and 2 should be filed within 72 hours af Health and Mental Hygiene. item 27 is marked other than "natural r traumatic event, the Medical Examin To Be Completed by		17. Father's Name (			addox				18.Mother's	s Name (First, Mi Lilli						
MD 21. d 2 should b th and Mer n 27 is mar numatic eve	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 5916 Johnson Street; Catonsville, MD 21228											1				
Baltimore, MD permit. Pages I and 2 sh Department of Health an Important: If item 27 i injury or other trauma	1	20a. Method of Disposition  1 XX Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposit crematory or other Arbutus Memory.						er place)			wn, State Yland					
Balti Dermit. Departm Imports njury o	Ī								s of Facility	wyrie ru		l Home, P.A				
Physician	1	23a. Part I. Enter the disease, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and														
/Medical Examiner		Immediate Cause (F or condition resultin	- Final disease	а.	Hypertensive Due to (or as a conse			ic cardio	vascula	ar disease			+	Death		
Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause															
ted msit	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):									7						
50, te be executed yysician and burial - transit	- E	X UNPENDED			#ZSa,PII,27	7.nerMF	E. 0876 . 2.	/25/08 TT				-				
OX 6876 eath certifica attending ph for use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   2   Fetal death   3   Ectopic pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   1   Yes 2   No 9   Unknown   9   Unknown   9   Unknown   1   Nother significant conditions   23e. Did									23d. Date of delivery  Month Day Year						
P.O. B res that the d signed by the be detached by the d by Ph.				_			contributing to death		_		given in Pa	ırt I. 23e		pacco use contribut		
ords, P.( w requires tha us been signed should be det	ב ב ב	Hepatitis	C, ten	nına	l renal dise	ease, c	cocaine us	<u>se</u>		1 24a	Yes . Was a	n   24b. Wer	e auto	psy findings available		
tal Records, P.C. tian: The law requires than certificate has been signed ector, page 2 should be det											autops perform Yes 2	ned? deat		npletion of cause of		
Vital Rec ysician: The l his certificate l director, page		25. Was case referr examiner?			lospital: 1 ✓ Inpatie	ent 2	ER/Outpatient		of Death (	(Check only one) Nursing Home	5 F	Residence 6	Other:			
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safer death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach artification: To Be Completed by P.		27. Manner of Death	5 Pen	ding	28a. Date of Inju (Month, Day,Y		28b. Time of In	jury 28c. Inju	ury at Work	? 28d. Des		ow injury occurred				
Division of To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After templetely filled in by the funeral Certification: Tedical Certification: Tedical Certification: T		2 Accident 3 Suicide 4 Homicide	6 Cou	stigation Id not the Immined	28e. Place of In	jury - At ho	me, farm, street	, factory, office	building, et		ation (S own, St		r Rura	I Route Number, City		
To the Hospi within 24 hou To the Funet completely fil					an: To the best of m											
T % T %		29b. Signature and title of certifier							29c, License number 29d, Date si O.C.M.E. February							
Ø		30. Name and addre			completed cause of d			reet, Baltim	ore, MD	21201						
State Registra	e	31. Date filed (Moh	Bay, Tean	20	08 32 egistra	r's Signatu	A.	Re)								
DHMH 17 Rev 1/2001	_						ORIGINAL	-		OCME						

		•	For State Registrar	Sta	ate of M	larylar		artmen rtificat				lental Hy	giene Reg. No.	200	8 0	+679		
	Physici	an	1. Decedent's Name (First, Mic	ldle, Last)					2. Date of De Month		Yea	3. Tim	e of Death					
	/Medi	cal	Pocom D Olivon											uary 9, 2008 9:10 PM				
	Examir	ier	Stella Maris	-		)			iown, or Lmoni		of Death			County of De Baltim				
	Funeral		5. Social Security Number	6. Sex	7. A	ge (In yrs.	last birthday)	If Under	1 Year	If Under		8. Date of Birl	_ !	9. B	irthplace (Sta	te or Foreign		
	Director		422-80-8946	1 ₹ M 2	2 🗆 F	52	Yrs.	Months	Days	Hours	Min.	June 5	y, Year) , 195	1 1	Country) `	unk		
	pur M		Usual Residence of Decedent 10a. State 10b. Cour			10c Cit	tv. Town or Lo	cation							10d Insid	e City Limits		
	f sho	ō	MD	.,				imore								Yes 2 □ No		
	28a-	rect	10e. Street and Number				Dait.	10f. Zip	Code				10g. Citiz	en of What	1 11			
	h with	a D	1831 Ramsay	Street				·	2	1223			_	USA	•			
	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral Director	11. Marital Status	unk 12. W	as Decedent med Forces	Ever in U	.S. 13.	Was Dece	dent of H	ispanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)	- 1	4. Race - An Black, Wi	nerican Indian	Ι,		
·ш.	after or it	J. Y	1 Never Married 2 M	arried 1 [	XiYes 2 □ Yes, Give	No		, 66, 6p6 1		Specify:		r nour, oto.,		Specify: b				
9:10 p.m. 21215-0036	hours tural	q pe	3 Widowed 4 Divorc	ent's Education	ear or Dates:		16a. Dece	dent's Heu	al Occup	ation				d of Busines				
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9:	d with giene rr tha	mo;	Elementary/Secondary (0-12) College (1-4or 5+) unk unk															
2008 aryland	e d al	To Be Completed by	17. Father's Name (First, Midd	le, Last)				u	nk	18. Mothe	er's Name	e (First, Middle,	Maiden S	Surname)		unk		
, 2 Mar			19a. Informant's Name/Relation		*		1					al Route Numb			, Zip Code)			
~	1 and Health 3m 27 ther tr	- 2	Stella Maris 20a. Method of Disposition	ноѕріс	е	20h I	2300 Place of Dispo			Valle		oad time			21093			
Baltimore,	Pages nent of H int: If ite		1 ☐ Burial 2 ☐ Crematio			,   '	cemetery, crei	matory or c	ther plac	e)		Jale	20c. Loc	ation - City (	or Town, State	•		
RUA	permit. Pag Department Important: I any Injury o		4 □ Donation 5 🖾 Other	7	n stat	e	22	Name ar	nd Addres	ss of Facilit	hv							
FEBRUARY   Baltimor	permit. Departr Importa any Inju		21. Signature of Euneral Servi	SWad	Pir	octo	r G	State Balti	Ana	tomy MD	Boar 212	d 655 W	. Ba	ltimor	e Stre	et		
	Physician /Medical		23a. Pa 11. Enter the dise se, show or heart failure. L Immediate Cause (Final disease or condition resulting in death)	a	is that cause use on each	2//2	h. Do not ent				cardiac		rrest,	od.		mate Between nd Death		
·	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Liter Underlying Cause (Disease or injury that initiated events	b. —	Due to (or as	s a conseq	uence of):											
8760,	ate be executed hysician and the burial-transit	cal	that initiated events resulting in death) Last	c	Due to (or as	a conseq	uence of);											
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 [ 4 [	yes, outcome □Live birth □Pregnant a □Unknown	2 Feta	aldeath 3	⊒Ectopic pi ∃Other (sp					23	3d. Date of o	lelivery Day	Year		
OLIVER tords, P	w requires that been signed to should be deta	þ	Part II. Other significant cond	itlons contributi	ing to death t	out not res	ulting in the u	nderlying c	ause give	en in Part I.					to the cause Probably 4			
ROGER OLIVER Vital Records, P		Completed				-						24a. Was autor perfo 1□ Yes		24b. Were prior to death		ngs available of cause of		
Z. Z.	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medi examiner?	eaí Hospita	al:				Othe			n (Check only o						
ō	iding Phys h. After this funeral dir	7 T	1 Yes 2 No 27. Manner of Death		^'' 1 ☐ Inpati a. Date of Inj		ER/Outpatier 28b. Time of		/A	4 ⊔ Nu		me 5 Residence 128d. Describe 1			pecify) HO	SPICE		
on	th. :: Afte	tion	1 Natural 5 ☐ Pend 2 ☐ Accident inve		(Month, Da		Injury	М	8c. Injun Work	k? Yes 2 ∐ l	- 1		,,	00001100				
Division	al or Attend s after death. al Director: A	Certification:	3 Suicide 6 Cou	d not be	e. Place of in building, e	jury - At ho tc. <i>(Speci</i> i	I ome, farm, str fy)	eet, factory	/, office			28f. Location (S City or Tox	Street and vn, State)	Number or	Rural Route f	lumber,		
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical (	(Check only 2 Medic		: To the best on the basis on and manner st	of examina	owledge, death ation and/or in	vestigation	, in my o	pinion, dea	nd place, ath occur	red at the time,	date and	place, and d	ue to the cau			
	Note of the state	-	29b. Signature and fitle of certi	fier		201	>	290	License	number	0%		29d. Date	-	nth, Day, Yea	r)		
			1//										_		0			
			30. Name and address of person							mT-10	TID-	V	.00					
	Sta	te	31. Date filed (Month, Day, Yea	ar)	2300 D 32. Regist		EY VALI	LEY R	U	TIMON	TUM,	MD 210	93					
	Registr	ar	FEB 1	9 2008	12	Total grade	S. Aller	MOD.										

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** KHAYA ORMAN February 16, 2008 5:19 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore Birthplace (State or Foreign Country) UKRAINE If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 X F Months Days Hours Min. 09/01/1916 91 282-74-5790 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Fshow notified at 1 ☐ Yes 2 No Directo MD BALTIMORE BALTIMORE 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 27 EMERALD RIDGE COURT 21209 UKRAINE Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner many injury or other traumatic event, the Medical Examiner many. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Black, White, etc. 1 Never Married 2 Married filmore, Maryland 21215-0036 1 □ Yes 2 No WHITE Specify <u>م</u> Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) RUVIN ORMAN BASHIVA UNOBTAINABLE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 EMERALD RIDGE COURT, BALTIMORE, MD 21209 IZABELLA SHTERENGARTS/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State HAR SINAI 4 □ Donation 02/17/2008 OWINGS MILLS, MD 5 ☐ Other (Specify) re Funeral Service Licer 21. Signat 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one case on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** pneumonia /Medical Due to for as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ZeNo Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 | Onknown this certificate has been si al director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2 ATNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**%** No 1 🔲 Yes 1 inpatient မ 2 ER/Outpatient 3□ DOA To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral ( 28b. Time of 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Registrar DHMH 17 Rev 1/2001

State

29a. Certifier

29b. Signature and title of certifier

har

Medical

SEEN KHAYA

and manner stated

son who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

MD

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

21204 - Mark Gosnell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month B POLINSKY 1400 M FEBRUARY 16, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE, MARYLAUD

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth

Affanth Park JOHNS HOPKINS BAYVIEW Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) September 1,1916 1 M 2 X F 181-05-2298 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Baltimore Dundalk Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 U.S.A. 45 Northship Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Û No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐XNo Specify: White Specify: 3X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 8 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Natalie Repella Adam Baruka 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1906 Wareham Road, Dundalk, Maryland Son Theodore Polinsky Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Michaels Ukrainian Cam 20, 2008 20c. Location - City or Town, State 20a. Method of Disposition X Burial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FATILIZE & DAYS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) a∏IJnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably ATRIAL FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an DIARRITES MELLITUS autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

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items 23a

or.

"natural",

and Mental Hygid

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau once.

and 2 should be

72 hours after

Saltimore, Maryland 21215-0036

the Medical Examiner must be

Director

Funeral

ģ

Completed

attending physician as the use for been signed by should be detac page 2

requires that the death certificate be executed

Box 68760,

P.O.

Division or Vital Records,

this certificate has After 1 death.

Physician/Medical ģ Completed Be မ Certification:

completely filled in by the funeral Medical

To the Hospital or Attenct within 24 hours after death To the Funeral Director;

Examiner

27 No 1 🗌 Yes

29a. Certifier

(Check only one)

27. Manner of Death 1 X Natural 2 ☐ Accident 5 ☐ Pending investigation 6 ☐ Could not be 3 ☐ Suicide 4 Homicide

Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

29b. Signature and title of certifier Sayon ,

D0066272

29c. License number

FEBRUARY 16, 2008

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURYAPRASAD, MD 494 d (Month, Pay, Year) 32 Registrar's Signature 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician GERTRUDE** PATRINICOLA 17 2008 FEBRUARY 2:10 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FOREST HILL HEALTH & REHABILITATION FOREST HILL HARFORD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) | Hours | Min. | Jan. 17, 1920 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Funeral 1 M 200 Maryland 88 Director 218-32-4344 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes <del>2</del> No MD Harford Forest Hill Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number r items 23a or 2 iner must be n 1 Colgate Drive 21050 USA by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23.

Lry or other traumatic event, the Medical Examiner must 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ☐Yes **XX**No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎗 🖸 No white Specify: XXWidowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Nelson Anna Doelle ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other trau once. 1148 Ridge Road-Pylesville, Maryland 21132 Paul Patrinicola-son 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Evans Funeral Chapel 1 ☐ Burial 2 ☐ Premation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-19.08 Forest Hill, Maryland And Cremation Ser. Belair 21. Signature of Funeral Service Licensee 3 Newport Drive EVANS FUNERAL CHAPEL AND CREMATION SERVICES Forest Hill, Maryland 21050 indrae 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** metastatio /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Ordering Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed burial-trans and A Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No Year for Day 5 ☐ Other (specify) 4 ☐ Pregnant at time of death ed by the a detached f 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? res 2 No certificate ha 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

State

01

Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DR. DAVID DUNN - 615 W. MACPHAIL ROAD - BEL AIR, MD 21014 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

03229

29d. Date signed (Month, Dav. Year)

18,2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** February Pohlner ndrew 21:22 M 2002 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center
5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthda If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/31/1960 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 15 M 2□ F Min 47 Yrs. 219-70-8090 Balt., Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County Maryland Baltimore Baltimore XXXYes 2 □ No Director 10g. Citizen of What Country? United States 10f. Zip Code 10e, Street and Number ral", or items 23a or Examiner must be r 713 S. Baylis Street 21224 America by Funeral of 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 🎘 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore City Dept. College (1-4or 5+) Elementary/Secondary (0-12) Meter Reader of Public Works 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank August Pohlner Dolores Sullivan ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kelli A. Pohlner/ wife 713 S. Baylis Street Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Februäry Important: If it any injury or o once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 18, 2008 4 Donation 5 Dother (Specify) Baltimore, Maryland 21. Signatur Freeral Service Liouse 22. Name and Address of Facility eaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stage Liver Disease **Physician** minth disease or condition resulting in death) /Medical Due to (or as a conse wence of): Examiner 10 years Alcohol Abuse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and al-transit The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown been signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sl autopsy performed? Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 40 1 Dipatient 2 ☐ ER/Outpatient 3□ DOA 2 this 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation filled in by the f 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN L. COOK, AVENUE BALTIMORE, M.D. Marisha

State

Registrar

31. Date filed (Month, Day,

32. Registrar's Signature

1 1 Pag

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State 31. Date filed (Month, Day, Year) 32, "Registrar's Signature		To the within To the comple	Me	29b. Signature and title of certifier	)	29c. Licens	se number	29	9d. Date signe	ed (Month,	Day, Year)
State 31. Date filed (Month, Day, Year) 32, "Registrar's Signature	)	2.		30. Name and address of nerson who completed cause of d	eath (Item 23a) (Tvr	De Print)	22 61	0.	4000	wory	10,2000
State Registrar S1. Date filed (Month, Day, Year) 32, Registrar's Signature 32, Registrar's Signature		100		latrice white	105 Fre	derrick R	1,# ZOZ	- Bald	L'more	40	82212
				31. Date filed (Month, Day, Year) 32, Pegistro	ar's Signature	South					

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** Poore 12:25 A<sup>M</sup> Lee 2008 Thomas February 18. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 2811 Calverton Blvd. Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 MM 2 □ F Director 579-44-5995 74 Oct. 31,1933 Washington, D.C. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 📉 No Director Silver Spring Maryland | Montgomery 10g. Citizen of What Country? 10e. Street and Number 20904 U.S.A. 2811 Calverton Blvd. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 M Yes 2 □ No
If Yes, Give 1956-1958
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education School Principal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leibrand Poore, Sr. Ada Carl Edwin 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2811 Calverton Blvd. Silver Spring, Maryland 20904 Margaret J. Poore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 2-19-2008 Maryland Towson 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) FIbrosi Pulmonary
Due to (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2000 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 ☐ Nursing Home 5 Sesidence 6 ☐ Other (Specify) 1 Yes ပ 21 No 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Antural 5 Pending investigation 1 TYes 2 TNo 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital or To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tile of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) the. Laurel, MD

Registrar DHMH 17 Rev 1/2001

State

MARGOLIS

31. Date filed (Month, Day, Year)

13952

2008

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene UUS 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 937 2008 **Physician** Price 7:29 p м Erika /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Edenwald If Under 1 Year | If Under 24 Hrs. B. Date of Birth Jan. 10, 1921 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Germany 1 □ M 2**X**□ F 87 212-30-4041 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State item 27 is markad othar than "natural", or itams 23a or 28a-f show othar traumatic evant. The Medical Examination unit be notified at 1 Yes 2X No Towson Directo Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21286 800 Southerly Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. s 1 and 2 should be filed within 72 hours atter of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 2 3X Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Travel Agent Travel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maria Hansert Gustav Ritter ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5701 Bahia Del Mar Circle St. Petersburg, Fl 33715 Mr. Guenter Sonntag/ Friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If itel
any injury or oth 1 Burial 2 Cremation 3 Removal from State 2/19/2008 Hilltop Service Co. Towson, Md. \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, 21. Signature of Fylgeral Service Licentee 1050 York Rd. Towson, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a conseque Examiner Sequentially list conditions, I day, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events Examine attending physician and for use as the burial-transit death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 ☐ Yes 2 ☐ No tuneral director. 25. Was case referred to medical 26. Place of Death (Check only one Be examiner' Other: Hospital: 1 🗆 Yes Mursing Home 5 - Residence 1 Inpatient 2 ER/Outpatient 3 DOA 6 ☐Other (Specify) of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Atter 1 X Natural 1 🗌 Yes 2 No death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title

Registrar

Year

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #1, perMD, g876 2/19/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** :08 8005 Morris Poole, III /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Maryland enmove 0 If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 **X**M 218-79-7208 10 Director 07 MD 04 01 Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits MD NA Baltimore 1√2Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a or 2 edical Examiner must be n 21225 U.S.A. 3435 Round Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 V Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Completed by Black 3 ☐ Widowed 4 ☐ Divorced the Medical F 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) the N/A N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill Health and Mental H tem 27 is marked otl Be Renee Waller Morris F. Poole Jr. traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3435 Round Road, Baltimore, Md 21225 Renee Waller-Mother permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Murial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 2/15/08 Randallstown, Md 4 Donation 5 Dother (Specify) 21. Signatur of Funeral Service License March F/H West 4300 Wabash Ave, 21215 Baltimore, Md Approximate Interval Between Onset and Death 23a. Palt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear vailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 190 monte /Medical Due (or as a c n s quence of): Examiner Sequentially list conditions Examiner Due to for as a conse mence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 21 No 1 Yes 3 Probably 4 Unknown Be Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2□No page 2 s autopsy certificate 2 □ No 1X Yes Physiclan: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: 2 PR/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 3□ DOA Certification: To 1 🔲 Inpatient this 27. Manner of Math 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 X Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide 24 hours a Funeral I 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grune Street Balto, MD RA South

State Registrar

31. Date filed (Month, Day, Year)

FEB

32. Registrar's Signature

**ORIGINAL** 

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Baltimore, Maryland 21215-0036

P.0.

Division or Vital

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State Registrar

31. Date filed (Month.

29b. Signature and title of certifier

ANDREW NONAKOWSKI 32. Régistrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

DO8096

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29d. Date signed (Month, Day, Year)

BELAIRS

FEBRUARY 13, 2008

MD

		1 - State Registrar	Cei	rtificate of l	Death		Reg. No	IUU	04691
		1. Decedent's Name (First, Middle, Last)				2. Date of De		Year	3. Time of Death
Physic /Medi		Robert Henry Parkerson				Feb 13	, 2008	rear	7:11 P <sup>M</sup>
Exami		4a. Facility Name (If not institution, give street and number)  3851 St. Barnabas Road T-2		4b. City, Town, or Suitla	Location of Death		4c. County Prin		eorge's
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. In the security Number 7. Age (In yrs. In yrs. In the security Number 7. Age (In yrs. In yrs. In yrs. In yrs. In the security Number 7. Age (In yrs. In y	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Do Aug 24	th 1936	9. Birthp Cour Wash	place (State or Foreign http) lington DC
		Usual Residence of Decedent	. Town and a					1,	Od Incide City Limits
show	_		, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 ☐ 🐈 o
natural", or items 23a or 28a-f show dical Examiner must be notifled at	Director	Maryland Prince George's		Suitland					
be n	Dir	10e. Street and Number 3851 St. Barnabas Road	т_ 2	10f. Zip Code 207	71.6		10g. Citizen of United		•
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iner i	E	Armed Forces?		Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Bla	ck, White,	etc.
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natur lical E	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	ation	kina	16b. Kind of B	usiness/In	dustry
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lygier her th nt, the	ပိ	10	Sale	s Clerk	18. Mother's Nam	o /First Middle	Reta		
ed ot	Be	17. Father's Name ( <i>First, Middle, L</i> ast) Otto Parkerson			Agath			110)	
nd Me mark matic	70	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street	9			. State. Zir.	o Code)
Ith ar 27 is r trau		Richard Parkerson (nephew)	I	3 Shannor					•
f Hea item othe		20a. Method of Disposition 20b. P		sition (Name of matory or other place		Date	20c. Location		own, State
nt: If		I Bunai 2 Cremation 3 Hemoval from State		atory Fel	1	18	Clinto	n, ME	)
Department of Health and Mental Hygiene, instrument of Health and Saar 28a-f show Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at anones.		21. Signature of Funeral Service Literisee		2. Name and Addre					
8 3 2 6		Korl Muser 963	A	lexandria	a Ferry R	coad, Cl	inton,	MD 20	)735 _
		23a. Part1. Enter the dis sign or complications that caused the death shock, or scart fail he. List only one cause on each line.	n. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between
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Adminict	<u>_</u>	Sequentially list conditions, b. Due to (or as a consequent	lence of):						
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ding physician and se as the burial-transit									
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ate has been signed by the attendir page 2 should be detached for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnat 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3[	□Ectopic pregnancy □ Other (specify)	/			ate of delive onth	rery Day Year
ned b	by Pl	Part II. Other significant conditions contributing to death but not rest	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use con	tribute to t	the cause of death?
en sig		Neuralgia				1 🗆	Yes 2 X No	3 ☐ Prol	babiy 4 □Unknown
s certificate has been si irector, page 2 should	Completed	Obesity				24a. Was	psv	prior to co death?	opsy findings available ompletion of cause of
	ပိ	Coronary Artery Disease 25. Was case referred to medical			26. Place of Dea		ormed? 2X No	1 ☐ Yes	2 No
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ath. Ir: Aff	Certification:	2 Accident investigation	injury		Yes 2 □ No				
er de irecto	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At ht building, etc. (Specification of the state of th		reet, factory, office		28f. Location City or To	(Street and Num own, State)	ber or Run	ral Route Number,
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within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)  1	wledge, deat tion and/or in	th occurred at the til ovestigation, in my o	me, date and place opinion, death occu	e, and due to the erred at the time	e cause(s) and m e, date and place	anner as s , and due f	stated. to the cause(s)
Vithin To th	Me	29b. Signature and jills of certifier		29c. Licens	e number		29d. Date sign	ed (Month,	, Day, Year)
		* */K		НО	59884		Feb 1	4, 20	008
1		30. Name and address of person the completed cause of death (Item	1 23a) (Type,	Print)					
0		Tinisha Jordon, M.D. 5100 Aut		Suitlan	d, MD 20	746			
	ate	31, Date filed (Month, Day, Year) 32. Registrar's Signa	ture						
Regist	rar	LEDIA TOON THEN SON	<b>建设工程</b>						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Joseph P. Porterfield February 8, 2008 6:13 AM M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Homewood Retirement Center Williamsport Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar 14, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 M 2 □ F Mary Tand 217-30-5809 84 Mar Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2 No Director MD Washington Williamsport 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 16505 Virginia Avenue 21795 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or ite any injury or other traumatic event, the Medical Examine 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify: Specify: white þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 minister religion 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Milton Perry Porterfield Myrtle Horst 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Porterfield/son 1007 S. Raleigh Street Martinsburg, WV 25401 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Done (Specify) 21. Sign store of Funeral Service Licenses 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street mi 21201 Baltimore. MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the bunial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records. P.O. Box 68760 signed by the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy for Month Year in the past 12 months? Day 5 ☐ Other (specify) ☐Yes 2☐No be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performe 2 No 1 TYes 1∐ Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner' Other: 2 No 1 🗌 Yes 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA 41 2 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Monner of Death 1 A latural 2 Accident 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 5 Pending investigation (Month, Day Year, М 1 ☐ Yes 2 ☐ No filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔍 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and ertifie

State Registrar 31. Date filed (Month, Day,

Year)

9 2008

32 Registrar's Signature

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

Month 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 DUnknown Were autopsy findings available prior to completion of cause of death? autopsy performed

2 No

7:00 AM

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

1 ☐ Yes 2XXVo

North Carolina

2008

Black, White, etc.

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D0030351

28c. Injury at Work?

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D 6

Hospital:

BON SECOURS

State

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After

ò

Completed

Be

Certification:

Medical

31. Date filed (Month, Day, Year)

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

0

9

5 Pending investigation

6 ☐ Could not be

determined

DHMH 17 Rev 1/2001

Registrar

2 ER/Outpatient 3 DOA

28h. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

			Please	Type or Print in I				-		-	
			For State Registrar	State of Marylar			of Health and of Death	Mental	Hygien Reg. N	71111	04693
r	Physici	an	1. Decedent's Name (First, Middle, Las		-			Mont	of Death	av Year	3. Time of Death
1	/Medi			Mufale Peterso	n			Febr		18, 2008	
	Examir	er	4a. Facility Name (If not institution, give				wn, or Location of Dea	th		c. County of Dea	
		2	Gilchrist Hospic  5. Social Security Number 6. S		last hirthday)	If Under 1	OWSON Year   If Under 24 Hrs	s. 8 Date		Baltimor	thplace (State or Foreign
Ŀ	Funeral Director	į		□ M 2 X F 73	Yrs.		Days Hours Min	July	of Birth h, Day, Yea 1, 19	34	Sicily
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	tor	10a. State MD 10b. County Howar		ty, Town or Lo	sville	-				10d. Inside City Limits 1 ☐ Yes 2X No
	h the r 28a r Doti	irec	10e. Street and Number			10f. Zip C	ode		10g. C	itizen of What C	ountry?
	th wit 23a o Ist be	<u>a</u>	906 Highstepper	Γrail			21784			USA	
9	be filed within 72 hours after death with the Marylar Ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give		Was Deceder If Yes, specify	nt of Hispanic Origin? ( Cuban, Mexican, Pue	Specify Yes rto Rican, etc	or No- c.)	14. Race - Am Black, Whi	te, etc.
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Maryland 21215-0036	n 72 h "natu	Completed by	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	dent's Usual ( kind of work DO NOT use	done during most of wo	orking	16b.	Kind of Business	s/Industry
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d 2	filed Hygie ther		17. Father's Name (First, Middle, Last)		Dan		18. Mother's Na	me (First, M			
an	12 should be fil h and Mental H 7 is marked ott traumatic even	To Be	Joseph Mufale				Anna	Arena			
3	d 2 should th and Mer 7 is marke traumatic	H	19a. Informant's Name/Relationship (7	Type. Print)	19b. Maili	ng Address (S	Street and Number or F	Rural Route I	lumber, City	or Town, State,	Zip Code)
	ind 2 alth a 27 is r trau		Mrs. Ann M. Martin	nson (Daughter	906	Highst	epper Trai	1 Syke	sville	e, MD 21	784
Je,	ss 1 and of Healt Item 2:	-	20a. Method of Disposition		Place of Dispo	matory or oth	er place) !	Date	- 1	Location - City or	r Town, State
<u>m</u>	Pages nent of I		1 ☐ Burial 2 <b>∑</b> ☐Cremation 3 ☐ 4 ☐Donation 5 ☐ Other ( <i>Specif</i> )	Removal from State   A 1	1 Coun	ty Cre	mation 2/2	1/2008	Syl	kesville	e, MD
Baltimore,	permit. Page Department ( Important: If any injury or once.		21. Signature of Funeral Service Licen	Haist no	0764 B	AIGHT	Address of Facility FUNERAL HOI Sykesville	ME & C	HAPEL 21784	, P.A.	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications to caused the dea	th. Do not en	ter the mode	of dying, such as cardia	ac or respirat	ory arrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. SCLERO  Due to (or as a consec	OERI		-			1	Onset and Death  UEHLS
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Δ.	quires that n signed b	þ	Part II. Other significant conditions of STROKE	ontributing to death but not res	sulting in the u	nderlying cau	se given in Part I.	23e.		use contribute t	to the cause of death? Probably
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Vit	e e	Be	25. Was case referred to medical examiner?	Hospital:	I EDIO		26. Place of De				1125 1
ō		. To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time o		4 Linursing	T		6 Other (Speury occurred	ecify) HOSPICE
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ivision	r Attend er death irector:	tification:	3 Suicide 6 Could not be determined			reet, factory, o		28f. Loca City	tion (Street a	and Number or F	Rural Route Number,

Division or Vital Records, P.O. Box 68760,

State Registrar

Medical Cer

29a. Certifier (Check only one)

29b. Signature and

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D64395

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 0 4 6 9 4

			1 - State Registrar			Cert	tificate of	Death		Re	g. No.	0	041	) ) 17
9	DET .	п	1. Decedent's Name (First, Middle, Las	st)						te of Death	Day Yea		3. Time of	Death
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	Examir		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, o	r Location of	Death		4c. County of De	eath		
		- 6	6 Sierra Circle				Owings M				Baltim			
	Funeral Director		5. Social Security Number 6. S 186–76–6899  Usual Residence of Decedent	ex	(In yrs. last birt	hday)_ (rs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (M	te of Birth onth, Day,		Birthplac Country Ghar		r Foreign
	and w		10a. State 10b. County	1.	10c. City, Town	or Loca	ation					10d	I. Inside Cit	y Limits
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	s 23s	Funeral	6 Sierra Circle	Apt. B	or in II S	12 14	21117 as Decedent of H		in? (Chaoifu V	an or No	Ghana 14. Race - Ai	norican	Indian	
	item item	Ľ.	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?		lf lf	Yes, specify Cuba	an, Mexican,	Puerto Rican,	etc.)	Black, W			
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Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licer	1 1 1 1 1 1			Name and Addre	•	11		leisterst			
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(	Physician /Medical		disease or condition resulting in death)	a. CON a	SEST	VE	HEAL	ET F	ALLUX	E			1 68	弘化
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P.O.	at the de by the a	hysi	1 ☐ Yes 2 No 9 ☐ Unknown	9□Unknown										
	res that signed to be deta	by Pi	Part II. Other significant conditions of	ontributing to death but	not resulting in	the und	derlying cause giv	en in Part I.	2	3e. Did tob	acco use contribute	to the	cause of d	eath?
Vital Records,	w require been sig should b	ed to	KONE					***	_	1 ☐ Ye	s 2 No 3□	Probab	oly 4 □ l	Jnknown
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<u> </u>		ĕ							1[	perform	ed2 death No 1 □ Y	1? `	□No	
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n	le le	e E	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. T	ime of njury	28c. Injui Wor			escribe hov	w injury occurred			
Sio	Attending r death. ector: After by the funer	cati	2 Accident investigation 3 Suicide 6 Could not be		v - At home, far	m etro		Yes 2□N		nation (Str	eet and Number or	Dural	Doute Num	hor
Division	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	111, 3016	et, factory, office			ty or Town,		nulaii	Todie Ivaiii	Der,
	spital ours neral		29a. Certifier 12 Certifying Ph	nysician: To the best of	my knowledge	, death	occurred at the ti	me, date and	l place, and du	e to the ca	use(s) and manner	as stat	ted.	
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in the Funeral Direction of the Funeral Dir	Medical	(Check only 2 Medical Exar	niner: On the basis of e and manner state		d/or inv	estigation, in my	opinion, deat	h occurred at	the time, da	ate and place, and	due to t	he cause(s	5)
	To the To the Comp	Ž	29b. Signature and title of certifier		1		29c. Licens			29	d. Date signed (M	on <i>th, Di</i>	ay, Year)	
			& Seus.	la Vo	De la	K	Do	930	745		07/18	/20	300	
	4		30. Name and address of person who											
	-		John S. Dalton,		Common	wea	1th Ave.	, Cato	onsvill	e, MD	21228			
	Sta Registi		31. Date filed (Month, Day, Year) FEB 1 9 200	2. Registrar	Signature	hea	A. A.							
			LED T 0 500	1	B									

Division or Vital Records, P.O. Box 68760,

 $\mathcal{L}_{\mathcal{K}\mathcal{L}} / |\mathcal{L}_{\mathcal{C}\mathcal{K}}|$  Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day, Year) B

(lexender

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mulemale MD



29c. License number

D0065819

29d. Date signed (Month, Day, Year)

February 13, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / De 1- State Amend 20c, perFH, g8/6, 2/19/08 TT C	partment of Health and Nertificate of Death	Mental Hygier	De () () 8	04696
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
	/Media		DORIS	POLT	Jels " 13	2008	12 -M
	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	tc. County of Death	,,,
			JEWISH CONVALESCENT & NURSING  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	BALTIMORE  v) If Under 1 Year If Under 24 Hrs.	8 Date of Birth	BALTIMOR	
	Funeral Director		219-07-2719 1 M 2 AF 86 Yrs.	Months Days Hours Min.	8. Date of Birth 02/19/192	Coul	place (State or Foreign offy)
	land ow		10a. State 10b. County 10c. City, Town or	Location		1	0d. Inside City Limits
	the Man 28a-f sh notified	<b>Funeral Director</b>	MD BALTIMORE BALTIN	IORE	100.0	Citizen of What Cour	1 ☐ Yes 2 ☐ No
	With Se or	Ö	7920 SCOTTS LEVEL ROAD	21208	109.	USA	iti y :
	death	era		3. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ	
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Baltimore,	ages 1 and of He and it: If Item y or other		20a. Method of Disposition  1	rematory or other place)	Date 20c. B 8/2008 <del> </del>	Location - City or To altimore ROSEDALE,	own, State
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760, €	Physician /Medical Examiner	Ical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not expected the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or influry that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	cecliel infants			Approximate Inferval Between Onset and Death
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of Vital Records,	The law requir	Completed	Seigne		24a. Was an autopsy performed?	prior to co death?	psy findings available impletion of cause of
<u>e</u>			25. Was case referred to medical	26 Place of Deat	1 ☐ Yes 2 ☐N h (Check only one)	No 1 ☐ Yes	2 No
<u> </u>	S S S	o Be	examiner? 1 Tyes 2 No Hospital: 1 Inpatient 2 ER/Outpat	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ome 5 Residence	6 ∏Other (Specif	iv)
0 00	ff fig.	tlon: T	27. Manner of Death  Natural 5 Pending (Month, Day Year)  Accident investigation	of 28c. Injury at	28d. Describe how in		,,
Division		Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, Sta		il Route Number,
	Hospil 4 hour Funer ely fills	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, de (Check only one)  1 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as s and place, and due to	tated. o the cause(s)
	To the within 2 to the Complet	Me	29b. Signature and title of certifier	29c. License number	29d. [	Date signed (Month,	Day, Year)
)			> fullyhon N)	AUC 217	Je	6.13.20	300
	7		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print) Refueles an	e Ralinh	in an	21211-
	Sta	te ar	31. Date filed (Month; Day, Year) 32. Registrar's Signature		13-0011	U R I C	0.17

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Date of Death Physician February /Medical 4c. County of Death Facility, Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner th more 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday, Birthplace (State or Foreign
 Country) **Funeral** 1 □ M 2 🕱 F March 23,1932 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 ₩ Widowed 4 Divorced Iac Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ 19a. Informant's Name/Helationship (Type. Print) (Brother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 20 4 Donation 5 to Other (Specify) Entombrent 22. Name and Address of Facility
TO Seph L. Rus 21. Signature of Funeral Service/Licensee Ave. negal Itome Baito Md 23a. Part f. Enter the discusse, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart fail re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Advanced Squamous cell Ca disease or condition resulting in death) months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Due to (or as a consequence of). ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home ဥ 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation Injury To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 🗌 Yes 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🛏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 02/14 2008 D0053928 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURALYA BEGUM, MD AVÈ BELVEDERE BALTIMORE W.

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Physicia
/Medica
Examine

Funera Director

the Maryland show ortant; If Item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items any injury or other trainment. Funeral Saltimore, Maryland 21215-0036 <u>م</u> Completed Be **Physician** /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transi Division or Vital Records, P.O. Box 68760, attending physician ō been signed by the a should be detached t þ Completed page 2 s To the Hospital or Attending Physician: the funeral director, Be this Certification: After after death. completely filled in by Medical

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year ELEANOR LOUISE KOGERS FEBRUARY 17 2008 4a. Facility Name (If not institution, give street and number, Ac. County of Death 4b. City, Town, or Location of Death HOLLY HILL MANOR TOWSON
I Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year) Baltimore If Under 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 1 □ M 2 🗶 F Months 93 259-48-3822 06-19-1914 MA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Baltimore Towson MD 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21286 USA 531 Stevenson Lane, LL3 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 K Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Medical Records Librarian Medical 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annie Mac Auley Edward J. Rogers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 49 Tanglewood Dr., Lake Oswego, Oregon David J. Boyle/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 2/19/2008 Towson, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death immediate Cause (Final disease or condition resulting in death) END STAGE PARKINSON BARS Due to (or as a consequence of) Sequentially list conditions, if only library to an action of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) IF FFMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 □ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 □Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 17-17041 FEB RUARY 18 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YORK ROAD #38 LUTHERVICLE UND MARCI. LEAVE 1205 31. Date filed (Month, Day, Year) 32. Registrar's Signature Same Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** a M Victoria W. Romans 15,2008 Queen epruae /Medical City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number 4c. County of Death Examiner Social Security Number if Under 24 H Date of Birth (Month, Day, 8 05 Birthplace (State or Foreign Country) (In yrs. last birthday **Funeral** Days Hours Year) Min. 1 □ M 2 □ F 237-18-0297 95 Director 08 NC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 X Yes 2 □ No MD NA Baltimore **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö must be 21201 U.S.A. 1100 Pennsylvania Ave #1407 23a permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonee. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Black Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u>Private</u> Cook 6th\_Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oueen Victoria Garrison Vance James 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 688 Sackman Street, Brooklyn, NY 11212 Mary E. Alleyne-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 2/22/08 Randallstown, Md 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, 21215 Baltimore, 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cardiac or respiratory arrest, Approximate Interval Between Onset and Death Im diate Cause (Final dease or condition resulting in death) **Physician** /Medical we to (or as a consequence f): Examiner WILLRE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 Unknown 1 Tes 2 No 3 Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mannel of Death filled in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

FEB

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For stete amend #26&30 Per Phy C8/6 2/19/08/The Certificate of Death

Registrar

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year KUSSEL - 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SIVER Spring, MD M If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Farland Nursing and Rehab Center

5. Social Security Number 6. Sex 7. Age (In yrs. last birthda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 1□M 217F Days Yrs. 216-36-6184 06-22-1922 Denmark Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√☐ No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Drive, Silver Spring, mo USA 2706 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Specify: white 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) medical secretary healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Steen Rasmussen Anna Christiansen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Everett Russell/spouse 12706 Springtree Drive Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 □Donation 5 🗹Other (Specify) in state State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

23a. Part1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPTICEMIA Due to (or as a consequence of) Sequentially list conditions, if any, leading to his nediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 🗹 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 4 XX ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗌 Suicide

**Examiner** physician and s the burial-transit the Hospital or Attending Physicien: The law requires that the death certificate be executed P.O. certificate has Division of Vital this After death. s after death

Physician/Medical Examiner by Be Completed

Certification; To Medicai

director, page 2 should be detached filled in by the funeral

**Physician** 

/Medical

**Examiner** 

Funeral

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28a-f show

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th and Mental Hygiene. 7 Is marked other than "natural", or Itame 23a or 28a-1 shov traumatic event, the Macical Examinat must be multiled at

Pages 1 and 2 should be filed within 72 hours after inent of Health and Mertal Hygiene.
ant: It Item 27 is marked other than "natural", or Ital

permit. Page Department of Importent: It any injury or once.

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

death with the Maryland

27. Manner of Death

29a. Certifier

6 Could not be determined 4 | Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

20906

To Medicel Exeminer: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

0 0 w 30. Name and address of person o completed cau f death (Item 23a) (Typ., Print)

1517 Hugo Circle

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

052261

Silver Spring, MD

Alan R. Segal MD. 31. Date filed (Month, Day, Year) 32 Aggistrar's Signature.

FEB 1 9 2008

DHMH 17 Rev 1/200

State

Registrar

within 24 hours a To the Funerel I

2

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No.2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month February 9 2008 6:51 P M Harold George Renegar 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Frederick Memorial Hospital Frederick Frederick 8. Date of Birth (Month Day, Mar 10, 6. Sex If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1 X M 2 □ F 83 texas 570-20-9606 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐Yes 2 ☐ No MD Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7431 Willow Road #14 21702 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) pilot military 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Clifford Renegar Floy McKenzie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Frederick Memorial Hospital 400 W. 7th Street Frederick MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State 4∑Donation 5 Other (Specify) 21. Signalure of Funeral Service Licensee Rona 11 S. Made 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Due to (or as a cons vuence of): Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not re≰ulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

The law requires that the death certificate be executed

Attending Physician:

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Hospital

Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Director

Funeral

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Completed

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**Examiner** 

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Examine Physician/Medical Completed by Be

attending physician and for use as the burial-transit certificate has been signed by the rector, page 2 should be detached funeral director, Certification: To ours after death.

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filled in by the fu within 24 hours a

To the Funeral I

completely filled

com	eny als	ley //s	ease	, ,	1 ☐ Yes 2 ☐	No 3 ♣Probably 4 Unknown
Chury	detu	inter sed	morary !	Reserve	24a. Was an autopsy performed? 1□ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referr	ed to medical		-	26. Place of Dea	ath (Check only one)	
examiner? 1 ☐ Yes 2∰	Ńο	Hospital: 1 ☐ Inpatient 2 ☑	ER/Outpatient 3	OOA Other: 4 Nursing F	fome 5 ☐ Residence 6	☐Other (Specify)
27. Manner of Death 1 ☑ Natural 2 ☐ Accident	n 5	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fact	ory, office	28f. Location (Street and City or Town, State)	f Number or Rural Route Number,
29a. Certifier	1 Certifying Ph	ysician: To the best of my kno	owledge, death occurr	ed at the time, date and plac	e, and due to the cause(s)	and manner as stated.

State Registrar (Check only

29b. Signature and title of certifier

FEB

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9th St / Frederick , Md. 21701 31. Date filed (Month, Day, Year) FFB 1 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month 6:15PM RICHARD ROBINSON FEBRUARY 15. 2008 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 506 N. KENWOOD AVENUE BALTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days 1 XM 2 ☐ F Director 42 MARCH 12, 1965 MD 216-94-2328 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 'natural', or items 23a or 28a-f show dical Examiner must be notified at 1 XYes 2 □ No Director BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 506 N. KENWOOD AVENUE Funeral Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE SUPERVISOR APARTMENT COMPLEX 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAMES ROBINSON DEBORAH THOMAS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BALTIMORE, MD 21205 506 N. KENWOOD AVE. ANTOINETTE ROBINSON/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MT. ZION CEMETERY 2-21-2008 BALTIMORE, MARYLAND 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signature of Funeral Service Licensee 1701-31 LAURENS ST. BALTIMORE, MD 21217 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as nse s IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐Live birth in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached to 1 Yes 2 No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 3 Probably 4 Unknown 2∏ № Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? res 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 TYes 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury al or Attendi after death. | Director: A 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funeral 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0051770 February 182008
1450 Orleans Street Balt mare Maryland 2031 pleted cause of death (Item 23a) (Type, Print)

State Registrar

FEB

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day "IlliAN Month Year 10:20 PM EESE 2008 /Medical FEB 13 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MA AGNES HEALTH CARE BALTIMORE 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Months Days Hours 1 M 2 N F 85 220-24-0948 Yrs. Director MARYLAND ctober 04 1922 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at BAltimore Director 1 NYes 2 No MARY and 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 3400 Royce U SA 21215 Funeral aue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🗷 No Specify: Completed by 3 Widowed 4 □ Divorced African AMERICAN the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kin of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) OWN Home Pomestic Worker. NIA f Health and Mental Hygie Item 27 is marked other I other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be ment of Health and Mental EllEN MACKALL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3400 Royce ave. Baltimore, AUDREY Johnson-MARYLAND Daughter permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Businal 2 □ Cremation 3 □ Removal from State BALLIMORE, MARY LAND 4 Donation 5 Dother (Specify) February 20,2008 22. Name and Address of Facility
WANCY M. WALLACE FUNERAL SERVICE
3405 W. FRANKLIN St. BAHIMORE MARYLAND 21229 21. Signature of Funeral Service Licensee Laucy m. Terelace 23a. Part1. Enter the lisease shock, or heart liure. L e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASPIRATION PNEUMONIA 3 NEEKS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) o 9 Unknown σ. signed by that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division or Vital Records, COR PULMONALE 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ◯ No 24a. Was an has autopsy performed? 1□ Yes 2X No this certificate Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1X Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 28c. Injury at Work? Injury 1 Natural 5 Pending investigation Accident 1 ☐ Yes 2 ☐ No filled in by the within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P19925 Punnam, MD Feb, 13, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PUNNAM, JYOTHI ST AGNES HEALH CARE, 900 CATON AVE, BALTIMORE-21229 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 1200 AM 18 2008 grary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Agnes Baltimore Hospita If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
 Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days 1□M 20F Months Hours Yrs. Director is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Director more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death \
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23s any Injury or other traumatic event, the Medical Examiner must once. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 □ Divorced Blac Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) taile 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ 21060 19a. Informant's Name/Relationship (Type. Print) (niece) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Terrace Burnie Jaki 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State Mem. Par 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Joseph L. Russ Fun
ZZZZ W. North Ave. 21. Signature of Funeral Service License uneral He 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): artery diseas antijour) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an perform 2 ☐ No certificate 2- No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No 2 ER/Outpatient 1 Tes 1 Inpatient 3□ DOA r within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined ò 1 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cepifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Calzin Ave Baltimore mD 21229 larp 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar
DHMH 17 Rev 1/2001

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		-	For State Registrar	State of Ma	ırylan		ertment of tificate o			-	giene Reg. No.	008		705
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	dica	-	Joseph			Smo	olko			Februa	ary 1	6,2008		AM
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Fune	ral		5. Social Security Number 6. Se	x 7. Age	(In yrs. i	ast birthday)	If Under 1 Ye	ar If Und	der 24 Hrs.	8. Date of Bir	th	9. Birt	hplace (State o	r Foreign
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and w			Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside Ci	ty Limits
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hould hould marke	1	<u> </u>	19a. Informant's Name/Relationship (T			19h Mailin	ig Address (Str					own State	Zin Code)	
nd 2 sulth ar			Dennis Smolko	Son		1	ildon C							
s 1 a			20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other	place)	Febr	dary		tion - City or		
Page ment annt I	.		1 X Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify		Oal	k Lawn	Cemete	ry	19,	2008	Dunda	ılk,MD.	•	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants if Item 27 is marked other than "natural", or items 23a or 28a-f show any Inlury or other traumatic event, the Medical Eaminer must be notified at	ouce.		21. Signature of Funeral Service Lice	100			onneily							
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12			shock, or heart failure. List only o	ne cause on each lir	e.					or respiratory a	inesi,		Interval Bet Onset and	ween
Physicia /Medic	1.0		disease or condition resulting in death)	a. CHRONIC Due to (or as			HEART 1	DISEAS	SE					
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alor A after ( Direct		Certification:	4 ☐ Homicide determined	building, etc	. (Specif	y)	-54, 1401019, 0111			City or To	wn, State)	varibei UI N	ural Route Nun	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely illied in by the funeral director, page 2 should be detached for use as the burial-transit		edical C		rsician: To the best of iner: On the basis of and manner sta	examina									s)
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Registrar
DHMH 17 Rev 1/2001

State

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD
31. Date filed (Month, Day, Year)
FEB 1 9 2008

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar			.,	_	ariment of F rtificate of		ZIIG IVI		leg. No.	2008	047	06
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/Me	edica	al -	RUTH 4a. Facility Name (If not in	FRAN		SL.	ACK	4b. City, Town, o	r Location o		FEBRUAR		2008 County of Deeth	11:40	A <sup>™</sup>
Exal	mine		ST. JOSEPH	-				TOWS		or Beauti			BALTIMO		
Fune	ral		5. Social Security Number			(In yrs. la	st birthday	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birth	place (State or F	Foreign
Direct	tor		310-24-5090 Usual Residence of Dece		M 2 <b>T</b> F 8	32	Yrs.				8/7/19			IESSEE	
land ow		-		County		10c. City,	Town or L	ocation						10d. Inside City	Limits
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ath w			4 AIRWAY C		APT. 1D			212				ŲS			
ter de Items		Funeral	<ol> <li>Marital Status</li> <li>Never Married 2</li> </ol>		12. Was Decedent E Armed Forces?		. 13.	Was Decedent of I If Yes, specify Cub	lispanic Ori an, Mexicar	igin? (Spe n, Puerto l	city Yes or No- Rican, etc.)	1	<ol> <li>Race - Amer Black, White</li> </ol>		
Ind 21215-0036  be filed within 72 hours after death with the Maryland ttal Hygiene. the hygiene of other than "natural", or thems 23a or 28a-1 show event, the Medical Examiner must be notified at		≥	37∏ Widowed 4□□		1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates:			1 ☐ Yes 2 🛣 No	Specify:				Specify: WHI	TE	
5-0 72 ho natur dical		Completed	15. D (Specify on	Decedent's Edu	cation le completed)		16a. Dece	dent's Usual Occup	ation during mos	t of worki	na	16b. Kin	d of Business/I	ndustry	
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Maryland 21215-0036 d 2 should be filed within 72 hours af th and Mental Hyglene. 7 Is marked other than "natural"; or traumatic event, the Medical Exam		<u>දු</u> -	12TH GRADE 17. Father's Name (First,	Middle, Last)			QUAL	ITY CONTE			TOR (First, Middle,		STINGHOU Surname)	ISE	
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Baltimo permit. Page Department of Important: If any Injury or	ouce		21. Signature of Furieral	Service Licens				<ol> <li>Name and Address</li> <li>LOCH</li> </ol>				N FU SON,		OME, P 286	Α.
		_	23a. Part1. Enter the dis- shock, or heart failu	ease, or compl	lications that caused to	he death.								Annrovimate	en
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/Medic Examin			resulting in death)		Due to (or as a	conseque	ence of):								
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at the de by the darched		JSI	1 ☐ Yes 2 🔀 No 9 ☐ Unknown		9□ Unknown										
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OF I Phys er this eral dii	_   F	2 -	1 ☐ Yes 2 ☐ No 27. Manner of Death		28a. Date of Injury	, 2	R/Outpatie 28b. Time (	III 3 DOA	4 🗆 Nu		me 5∐ Resid 28d. Describe h		Other (Spec	eify)	
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Or Attendate death Director: in by the	.		3 ☐ Suicide 6 ☐ 4 ☐ Hornicide	Could not be determined	28e. Place of injur building, etc.	y - At hom (Specify)	ne, farm, st	reet, factory, office		2	28f. Location (S City or Tow	treet and	d Number or Ru	ral Route Numb	er,
DIVISION OF VITA Hospital or Attending Physician: 43 hours after death. Funeral Director: After this certific edity filled in by the funeral director.															
DIVI  Hospital or Al  24 hours after of Funeral Direction by	. 3	edical	29a. Certifier 1 (Check only one)	Jeπitying Phy Medical Exami	sician: To the best of Iner: On the basis of and manner stat	examinatio	reage, dea on and/or i	in occurred at the ti nvestigation, in my	me, date ar opinion, dea	nd place, a ath occurr	and due to the or red at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
To the Hos within 24 ho To the Fun completely			29b. Signature and title o	f certifie	- Individual			29c. Licens	se number		2	29d. Date	e signed (Monti	n, Day, Year)	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 2 iteine 2008 6 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Flospice Center altimore If Under 1 Year 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 K Months Days Hours Min 219-30-4008 Director Maryland Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Saltimore Itimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or items 23a or Examiner must be r 21220 by Funeral pad death Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 🕅 No Specify. Specify: 3 Widowed 4 □ Divorced white Year or Dates: Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Genera lelephone 12 berator or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental Important: If item 27 Is marked or any injury or other traumatic everoce. Clara Daylor eorge ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pond View L Charles 17973 Stewartstown ane Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 2-21-2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemeter 22. Name and Address of acility Evans Funeral Chapel & Cremation Services - Mirkville 8800 Harford Road Parkville mb 21234 21. Signature of Funeral Service Licensee ai 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ancer **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed buriat-tran Due to (or as a consequence of) attending physician Physician/Medical the as 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy ģ Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown detached 9 Unknown er uns ceruficate has been signed reral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, Be Completed by 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) D. Ce 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 TYes 1 Inpatient Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ospital or Attending 1 Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No within 2 hours after death.

To the uneral Director: A completely filled in by the fu 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death-(item 23a) (Type, Print) 0 6701 N. Charles S. Balto BMC 32 Registrar's Signature

State

Registrar

31. Date filed (Month, Day,

Year)

2008

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death STURGEON Year 3:03 P M FEBRUARY 17 2008 4a. Facility Name (If not institution, give street and number) FIJWARD COUNTY GENERAL HOSPITAL 4b. City, Town, or Location of Death HOWARD COLUMBIA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/12/1927 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Days 1 □ M 2 X I 212-22-0860 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore MD Owings Mills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 915 Rachel Jordan Court 21117 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: if Yes, Give Year or Dates: Specify: White 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Worker Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Smith Pauline (Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Larry Schultz (Son) 915 Rachel Jordan Court, Owings Mills, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ➡Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Meadowridge Memorial: 02/20/2008 Elkridge, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. Male T. 25 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PNEUMONIA 24 Hours disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CONGESTIVE HEART FAILURE 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No CHRONIC ORSTRUCTIVE PULMONARY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Appatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

Physician /Medical Examiner Examine The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28a-f show must be notified at

Items 23a

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"natural"

Health and Mental Hygiene. Iem 27 Is marked other than other traumatic event, the M

Item 27 I

permit. Pages Department of Important: If it any injury or o once.

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Funeral

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Completed

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and bunial-t physician the burial signed by the a certificate has irector, page 2 or Attending Physician: after death.

I Director: A in by the fu

Completed by Physician/Medical

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Certification:

Medical

Division or Vital Records, P.O. Box 68760,

9 Unknown 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 Homicide

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatore and title of certifier

INTENSIVE CARE UNIT PHYSICIAN

29c. License number D0060563

29d. Date signed (Month, Day, Year) FEBRUARY, 17,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOHAMMED ALATTAK

10 LAS CEORE (AND COLUMNIA MARYLAND 2.1) State

29a. Certifier

(Check only one)

31. Date filed (Month, Day, Year) 1 9 2008 FEB

AN 6 32. Registrar's Signature

Registrar

within 24 hours and
To the Funeral Dir

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of Ma	aryland	-	artment o' <i>tificate d</i>			_	giene Reg. No.	2008	04709
			Decedent's Name	e (First, Middle, Las	")						2. Date of De Month		Year	3. Time of Death
	Physicia Medic		Rober	ct Lo	ouis	Subo	ck, S	r.			Feb,	15	,2008	11257 AM
	Examin	5-22160	4a. Facility Name (If	_	street and number)			4b. City, Tow				4c.	County of Dea	711
44.00	and the same of th		5. Social Security N	NDALE umber 6. Se	7 400	e (In yrs. lasi	t hirthday)	If Under 1 Ye		NORE Inder 24 Hrs.	8. Date of Bir	th	9 Bir	thplace (State or Foreign
Н	Funeral Director		219-28-23	1.5	₽M 2□F	76	Yrs.	Months Da		ours Min.	(Month, Da	ıy, Year)	C	ountry) cryland
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	anylan show d at	ŗ	10a. State	10b. County		10c. City, T								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he Ma 8a-f	Director	MD 10e. Street and Nur	Baltimore	2	Ran	dalls		-			10a Citi-	zen of What Co	
	a or 2	ä		wnhill Roa	5.			10f. Zip Cod	133				JS	oundy:
	ns 23	Funeral	11. Marital Status	WILLIAM TOO	12. Was Decedent B	Ever in U.S.	13. V			ic Origin? (Sp	pecify Yes or No Rican, etc.)		14. Race - Ame	
9	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Examiner must be notified at	Fur		ied 2½ Married	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give	10		t Yes, specify ( 1 □ Yes 2 √2		exican, Puerti ec <i>ify:</i>	o Rican, etc.)		Black, Whi	<sub>te, etc.</sub> Ihite
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	il Hygi other ent, t	Be C	17. Father's Name (	(First, Middle, Last)					18.	Mother's Nam	ne (First, Middle	, Maiden	Surname)	
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			☐Cremation 3 ☐		cem	netery, cren	matory or other Mem. I	place)	Fob	20,2008		•	
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	/Medical Examiner		resulting in death)		Due to (or as	a consequer	-							
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Division or Vital Records,	Atter	ifica	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of inju-		e, farm, str	eet, factory, of	ice			(Street an		Rural Route Number,
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	To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death.  To the Funeral Litrector: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	cal	29a. Certifier (Check only one)	2 Medical Exam	ysician: To the best of tiner: On the basis of manner sta	f examination	n and/or in	vestigation, in	my opinio	in, death occu	irred at the time	, date and	l place, and du	ue to the cause(s)
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ì	5+1	1	30. Name and addr	ress of person who o	completed cause of d	eath (Item 2	3a) (Type,	Print)			File			
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene of Action

			For State	State of Maryla		nt of Health and N te of Death	nemai mygien Reg. N		04/10
			Registrar  1. Decedent's Name (First, Middle,	Last)			2. Date of Death		3. Time of Death
	Physicia /Medic		Elnora	Smit	-h			ay Year 6 200%	1346 PM
	Examin	AL	4a. Facility Name (If not institution,			, Town, or Location of Death	4	c. County of Deat	11.
1				Gyland Medical  S. Sex 7. Age (In)		er 1 Year   If Under 24 Hrs.	8. Date of Birth	9. Birt	hplace (State or Foreign
	Funeral Director		218-28-2200	1 M 25€	77 Yrs. Months		8. Date of Birth (Month, Day, Yea		Untry) ARVLAND
×	Mary Mary Mary Mary		Usual Residence of Decedent				11 -12 12,1		7
	arylan show 1 at	<b>.</b>	10a. State 10b. County	10c.	City, Town or Location	2	- 0'		10d. Inside City Limits 1 X Yes 2 □ No
	Ba-f s	ecto	MARYLAND 1	JA	100.7	DALTIMORE		itizen of What Co	
	a or 2 be n	D.	10e. Styleet and Number	A 11 A		ip Code	7	nuzen oi what co	antry?
	leath ns 23 must	Funeral Director	11. Marital Status	12. Was Decedent Ever in	VENUE 13. Was Dec	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ame	
0	after or iten	Fun	1 ☐ Never Married 2 ☐ Marrie	Armed Forces?  d 1 ☐ Yes 2 No If Yes, Give	If Yes, sp 1 ☐ Yes		o Rican, etc.)	Black, White	e, etc.
3	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	3 X Widowed 4 □ Divorced	Year or Dates:				Specify: BL	ACK
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2	Pages 1 nent of H nt: If ite iry or otl		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation	Removal from State	b. Place of Disposition (N cemetery, crematory of	r other place)	Date 20c.	Location - City or	Town, State
Dallillo	ant ant		4 □ Denation 5 □ Other (Sp. 21. Signature of Funeral Service )	17	HIG MEM.	PARK 02-	2208 00	DODLAU	N, MARYLAND
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r			23a. Part1. Enter the disease, or o	omplications that caused the c	death. Do not enter the m	ode of dying, such as cardiac	or respiratory arrest,	77010 . 77	Approximate Interval Between
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E	/Medical		resulting in death)	Due to (or as a con					-
	Examiner	<u>.</u>	Sequentially list conditions,	b. Small Due to (or as a con	Cell lung	(ancer			
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a con	isequence or,				
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א מ	leath certi attending I for use a	ian/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pre	Fetal death 3 ☐ Ectopic			23d. Date of de Month	livery Day Year
5	he de the a	Physician/M	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	of death 5 Other (	specify)			
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burfal-transit	Medical (		Physician: To the best of my xamlner: On the basis of examiner and manner stated.					
	To the within (	Mec	29b. Signature and title of certifier	and manner stated.	2	29c. License number	29d. I	Date signed (Mon	th, Day, Year)
Ì	-		1 Alson	MD		P-21195	21	111/2009	1
1	1		30. Name and address of person w	ho completed cause of death					
Ø	gar		Joseph Hzas Ja 31. Date filed (Month, Day, Year)	5. Greene St.	Baltimore,	MD 21201			
	Sta Registr			32. Registrar's S	is bearles				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death EBRUARY Day 12, 2008 **Physician** /Medical 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Baltimore If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 MM 2 □ F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1XYes 2 No Director MARILAND 10e. Street and Number 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ROGRADE 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other to 20a. Method of Disposition 20c. Location - City or Town, State 1, Burial 2 □ Cremation 3 □ Removal from State WOODLAWN, MARILAND 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee BROWN 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIO PULMONARY ARREST 2HOURS /Medical Due to (or as a consequence of): Examiner END STAGE RENAL DISEASE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner anding physician and use as the burial-transit DEMENTIA Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical ANEMIA IF FEMALE: 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐Fetal deal
4☐Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1☐ Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death
1 X Natural
2 ☐ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Z Medical Examiner: On the basis of examination and/or investigation in my policing doubt. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of pertifler 29c. License number 29d. Date signed (Month, Day, Year) D0059283 February 13, 2008 person who completed cause of death (Item 23a) (Type, Print) RICHARD ADDO M.D. 7601 OSLER DRIVE TOWSON. MARYLAND 21204 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 9 2008 Registrar

certificate has tirector, page 2 s i 24 hours after dearn. Le Funeral Director: After this certificaletely filled in by the funeral director,

Be

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Certification:

Medical

25. Was case referred to medical

Fo the Hospital or Attending Physician:

24a. Was an

autopsy

							1☐ Yes 2 No
					26. Place of De	ath <i>(C</i>	heck only one)
Inpatient	2 🗆	ER/Outpatient	3 🗆 🛭	OOA	Other: 4 \( \text{Nursing} \)	lome	5 Residence
e of Injury		28b. Time of			Injury at		. Describe how inju

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ E	OOA Other: 4 Nursing H	lome 5 Residence 6 Other (Specify)	
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3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, street, factor building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	nysician: To the best of my knowledge, death occurre		and due to the cause(s) and manner as stated.	

29b. Signature and title of certifier

29c. License number 726833

Benning mary cor 0 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IN CHANCES STREET

and manner stated

31. Date filed (Month, Day, Year) FEB



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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year PM Ethel Smith Μ. February 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bel Air Health and Rehabilitation Ctr Hartora 5. Social Security Number 8. Date of Birth (Morth Day, Year) April 11, If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2□F 235-18-9304 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show "natural", or items 23a or 28a-f sho dical Exaπiner must be notlfied at 1 ☐ Yes 2 🕅 No MD Harford Forest Hill Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1910 Jean Court 21050 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 2 Specify: White 3 X Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home Department of Health and Mental Hy, Important: If item 27 is marked othe, important: If item 27 is marked othe, any injury or other traumatic event, is once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Styers ဥ Eula Spriggs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Smith-son 1910 Jean Ct., Forest Hill. MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 2/21/08 Parkville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Successee William G. Dau 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the dearn. Yo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician mon. /Medical Due to (or as a cons quence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical is certificate has been signed by the attending director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown onificant conditions contributing of death but of resulting in the underlawed use given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 🗌 Yes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy 1□ Yes 2□ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: All completely filled in Extra 1 Tyes 2 🗆 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature ap 29c. License number person who completed cause of death (Item 23a) (Type, Print), 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Floride H. Seipp 15, 2008 10:56 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 21, 1918 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ☐ M 2 🔀 F Maryland 89 220 05 7830 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Baltimore Essex Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1000 Franklin Ave. Apt. 1005 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 🔀 No þ 3 XWidowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Mentail Earl Hewitt Edith Blaney 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) tem 27 is Janice Troutman (Daughter) 1305 Vermont Rd. Bel Air, Maryland 21014 Pages 1 a 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State Gardens Of Faith Cemetery 2/21/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service License Bruzdziński Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to instruction cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1☐ Yes 2ÊNo Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

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31. Date filed (Month, Day,

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Registrar
DHMH 17 Rev 1/2001

32. Registrar's Signature

500 Upper Chesapeake Drive, Bel Air, mp 2/014

Darring C, wal yland 2 12 10 000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "naturar", or items 23a or 28 and 29 and injury or other traumatic event, the Medical Examiner must be no once.	
Division of vital necords, P.O. DOX 60/60,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	
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/Medica		4a. Facility Name (If not institution, give street and number)				4b. City, Town, or	Location of Death		4c. County			
_		Pe 5. Social Security N		Assisted 6. Sex	Living  7. Age (In yrs.		Pasad If Under 1 Year		8 Date of Rin		e Arundel.  9. Birthplace (State or Foreign	
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te Funera	Medical C									nner as stated. and due to the cause(s)		
To the	ğ	29b. Signature and	itle of certifier	tome	rh.	0.0	29c License	number			d (Month, Day, Year)	
à		30. Name and address of person who completed cause of death (Item 23a) (Typ				1 (D)	1714160			February 18, 2008		
6		Harjit					Highway	Brook1	lyn Park	, Maryla	and 21225	
Stat Registra		31. Date filed (Mon			legistrar's Sign		and .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Amend #14, perFH, g876, 2/19/08 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician shmai 1902 M Samie 2008 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Hospital Baltimore, MD Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Days Director 212-77-0042 08 19 MD Usual Residence of Decedent death with the Maryland 10a. State 7 is marked other than "natural", or itams 23a or 28a-f ahow traumatic avent, the Modical Exaction must be notified at 10c. City, Town or Location 10d. Inside City Limits Y☐Yes 2☐No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3016 Mary Ave 21214 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Copartment of Health and Mental Hygiene. Important; if tem 27 is marked other than "natural", or its may injury or other traumatic avent, the Madical Extra direction. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Black by Specify: 3 Widowed 4 Divorced Year or Dates: Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Gopaul Singh Sayeeda Samie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Abdul Samie-Grandfather 3016 Mary Ave, Baltimore, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State King Memorial Park 2/17/08 Randallstown, Md \* 4 Denation 5 Other (Specify) 21. Sinate e of Funeral Service Licensee) 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, 21215 23a. Part 1. Enter the sease, or complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart in livre. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multi-Lobar pneumonia **Physician** 1 days /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence Examiner or Attending Physician; The law requires that the death certificate be executed the burial-transit attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Completed by Physiclan/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Yes 2 Z No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 2 ER/Outpatient 3□ DOA Aiter th funeral 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Il Director: A 1 ☐ Yes 2 ☐ No death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Direct Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Dey, Year) RES-000 16/08 ause of death (Item 23a) (Type, Print) 600 N. Wolfe St, Baltimore, MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [ 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month February12,2008 James H. Stallings Jr. 10:45 ™ /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1420 Dr. Jack Road Conowingo Cecil 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 234-72-2676 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director MD Cecil Conowingo 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1420 Dr. Jack Road 21918 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after in and Mental Hygiene. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 þ 1 ☐ Yes 2XXIo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 9 Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Depertment of Health and Mental Important: If Item 27 is marked c eny liqury or other traumatic ever page. James Stallings Sr. Mary Lou Durbin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret G.Stallings/Wife | 1420 Dr. Jack Road Conowingo, MD 21918 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/15/08 Baltimore, MD Holly Hill 21. Signature of Funeral Service License 22. Name and Address of Facility 300 Connelly Funeral Mace Home Avenue Baltimore of Essex MD 21221 23a. Part T Enter the discusse, or complications that cau led the shoot, or heart failure. List entrone cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequende of): Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Dua to (or as a consequence of) law requires that the death certificate be executed physicien and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. | signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccouse contribute to the cause of death? Division of Vital Records. þ Completed 3 ☐ Probably 4 ☐ Unknown certificate has b irector, page 2 sl 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2000 1□ Yes director. Be 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No After the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 🗌 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter To the Funerel Direct 4 - Homicide Hospitel or filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ŧ 29b. Signature and title of certifier 29c. License number 29d. Date/signed (Nonth, Day, Year) 30-Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Simonson MD III West 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

32. Relistrar's Signature

FEB 19

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year Mark E. Sowards Jr. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ranklin Sq Lave If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Y Sept. 24 Birthplace (State or Foreign Country) **Funeral** Age (In vrs. last birthday) Days Hours 1 M 2 □ F 213-38-8414 MD 65 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Baltimore Essex MD 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 21221 10e. Street and Number 958 Kinwat Avenue "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No ğ Specify. Specify: Pages 1 and 2 should be filed within 72 hours in nent of Health and Mental Hygiene. White 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. tem 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Plastics Company Supervisor 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thelma Knight Mark E. Sowards Sr. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 958 Kinwat Avenue Baltimore MD 21221 1 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai once. Judith F. Sowards /wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 2/18/08 Baltimore MD 22. Name and Address of Facility 300 Mace Ave, 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. De shock, or heart failure. List only one cause on each line. t enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Carc disease or condition resulting in death) /Medical Due to r as a consequence of): Examiner Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical e attending pl as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 🗌 Yes 2 No 3 Probably 4 donknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 2 1 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 R/Outpatient 3 DOA Certification: To 1 🔲 Inpatient this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of contifier 29c License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Drive Baltimore Md. 21237 r. Eveline 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

01

	1- State of Marylar Registrar	nd / Department of Healt Certificate of Dea		rgiene 2008 Reg. No.	047			
ian cal	1. Decedent's Name (First, Middle, Last)  Dolores A. Schenning		2. Date of De Month Februar	eath Day Year	3. Time of Death			
ner	4a. Facility Name (If not institution, give street and number)  FRANKLIN SQUARE HOSPITAL CEN  5. Social Security Number  213-28-4001  1□M 2  FRANKLIN SQUARE  7. Age (In yrs.		der 24 Hrs.   8 Date of Bi					
.or		ity, Town or Location Baltimore			10d. Inside City Lir			
Funeral Director	10e. Street and Number 604 Riverside Road	10f. Zip Code	221	10g. Citizen of What Cou USA	intry?			
þ	11. Marital Status  1 □ Never Married 2 ▼ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in L Armed Forces?  1 □ Yes 2 ™ No If Yes, Give Year or Dates:	J.S. 13. Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 □ Yes 2 XNo Spec		14. Race - Amer Black, White Specify: Wh	, etc.			
Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during r life. DO NOT use retired)		Baltimore				
To Be Co	17. Father's Name (First, Middle, Last)  Joseph Regulski			irst, Middle, Maiden Surname) atajczak				
	19a. Informant's Name/Relationship (Type. Print) Bernard Schenning/Husband	19b. Mailing Address (Street and Nu 604 Riverside		•				
	3635	Place of Disposition (Name of cometery, crematory or other place)  Lair Memorial  22 Name and Address of Face	!	20c. Location - City or 1 8 Belair,	MD			
4 %	I color flux amily	22. Name and Address of Fa  Connelly Fu			MD 212			
lical Examiner	Sequentially list conditions, large Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consect of the condition of	Failure						
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of o	al death 3 ☐ Ectopic pregnancy		23d. Date of deliv	/ery Day Year			
þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to							
Completed			24a. Was auto perfi 1 Yes		opsy findings avail ompletion of cause 2□ No			
To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2	Other:	lace of Death (Check only)  Nursing Home 5 Res		ify)			
Certification:	27. Manner of Death  1 Natural 5 Pending Investigation  3 Suicide 6 Could not be determined 4 Homicide 28a. Date of Injury (Month, Day Year)  28a. Date of Injury (Month, Day Year)  28b. Place of injury - At houiding, etc. (Special Special	28b. Time of Injury at Work?  M 28c. Injury at Work? 1 ☐ Yes 2  nome, farm, street, factory, office  ffy)	2 □ No 28f. Location (	how injury occurred  (Street and Number or Ruley)	ral Route Number,			
Medical Cer	29a. Certifier  1	owledge, death occurred at the time, dat ation and/or investigation, in my opinion,	e and place, and due to the death occurred at the time	e cause(s) and manner as , date and place, and due	stated. to the cause(s)			
Me		DOO, M.D. 29c. License numb	6475T	29d. Date signed (Month 2/13/08	, Day, Year)			

Certificate of Death

2. Date of Death

Month

Day 14,

Specify:

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Month

23e. Did tobacco use contribute to the cause of death?

24a. Was an

autopsy performed? Yes 2 2 No

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

(unknown)

<sup>Year</sup> 2008

1. Decedent's Name (First, Middle, Last)

4c. County of Death Howard Birthplace (State or Foreign Country) NY 10d. Inside City Limits 1 ☐ Yes 21 No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. White 16b. Kind of Business/Industry Self Employed 20c. Location - City or Town, State Farmingdale, NY

Inc.

Approximate Interval Between Onset and Death

Year

9:25 am

the Hospital or Attending s after death

28f. Location (Street and Number or Rural Route Number, City or Town, State) 23a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Reg strar's Signature Year)

Medical

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2:00 A M Mary Gerker Simon Feb. 17 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris
5. Social Security Number Timonium Baltimore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 💢 F Months Hours **Director** 80 500-24-6691 May 7 1927 Michigan Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County must be notified at 1 □Yes 2 ☑ No Director Parkton MD Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 2735 Mt. Carmel Rd. Funeral 21120 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace · American Indian. Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: white 2 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary G. O'Hargan Bernard Gerker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and Important: If Item 27 Is many Injury or other traum Mary Frances Palmer/daughter 2735 Mt. Carmel Rd., Parkton, MD 21120 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 2/22/08 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Memorial Gardens Timonium, MD 21093 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
0 W. Padonia Rd., Timonium, MD 21093 21. Signature of Funda Ser ce Licenses Michael 23a. Part1. Enter the disease, or conshock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 2 months? 3 ☐ Ectopic pregnancy Month Year 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has 50000/10 To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 No Other: 6 Other (Specify) P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 124 hours a 29a. Certifier Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 18

Registrar

Baltimore, Maryland

, 2008 Box 68760,

FEBRUARY | Records, 1

MARY SIMON Division or Vital

2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

EDDIE NAKHUDA, M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Catherine Aurelia Singer February 17, 2008 8:40pm /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 631 Lynn Way Sykesville Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 27 19 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Months 1 □ M 2 🗑 F Yrs. 63 216-42-9256 Director 1944 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Carrol1 Eldersburg Director 1 ☐ Yes 27 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 631 Lynn Way 21784 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married A Married 1 ☐ Yes 2√ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Md. Dept. of the Elementary/Secondary (0-12) College (1-4or 5+) environmental health inspector Environment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Lloyd Dorsey Mary Aurelia Yinger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Ed Singer (spouse) 631 Lynn Way, Eldersburg, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Memorial 2-21-08 Marriottsville, MD 4□Donation 5 NOther (Specify) entombment 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityHaight Funeral Home & Chapel Daige Haught Steubert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Brast Physician 640 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 4□Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes No No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No perform 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of Medical Certification: Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after common to the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide TEX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) tanada 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GBMC Just 510 3 Fara Alexa . Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 9 2008 1

28a-f show traumatic event, the M-dical Examiner must be notified ŏ Strenstly Byrrar or items 23a 2 should be filed within 72 hours after and Mental Hygiene.

Is marked other than "natural", or Itel Baltimore, Maryland 21215-003 Known as permit. Pages 1 and 2: Department of Health at

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Physician /Medical Examiner

Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

physician the as this

Physician; The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Byron George Stronsky February 0330 16 200B 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Hospital of Baltimore altimore Year If Under 24 Hrs.
Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months 1 M 2 □ F Days 90 212-07-3368 Jan 27 1918 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Carrol1 Sykesville 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7139 Harlan Lane 21784 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) aviation aircraft mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virginia Marion Kline George Bernard Stronsky 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy K. Stronsky (spouse) 7139 Harlan Ln., Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial 2-19-08 Sykesville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Dauge Haught 3 P.O. Box 195, Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ceremovanular disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No Was autopsy performed? 24a. Was an 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signatur 29d. Date signed (Month, Day, Year) wo MO 1)63282 tehnany 16, 2008 iress of person who completed cause of death (Item 23a) (Type, Print) Sinai Hosm tal of Baltimore 2008 10 1948 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2008 State of Maryland / Department of Health and Mental Hygiene Frank A. Spadaro, Jr. 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 12, 2008 1040 hrs Medical Examiner Frank A. Spadaro, Jr 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Glen Burnie 7879 Twin Ridge Drive 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Months Hours Min Days Director Country) 1962 45 Yrs 27, 216-48-8969 1X M 2 F Sep. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X X No Anne Arundel Glen Burnie Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 7879 Twin Ridge Dr. 21061 USA 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Armed Forces? 1 Never Married 2 XXMarried Yes White Yes 2XX No specify: Specify: f Yes, Give Year 3 Widowed 4 Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "! injury or other traumatic event, the Medical I. Baltimore, MD 21215-0036 Detective Police 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank A. Spadaro, Sr. Ethel Ryder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Mrs. Mary Spadaro / Wife 7879 Twin Ridge Dr.; Glen <u>Burnie, MD 2106</u> 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20 crematory or other place) February 1 X Burial 2 Cremation 3 Removal from State 2008 Glen Burnie, MD <u>Glen Haven Memorial</u> Donation 5 Other Specify: 22. Name and Address of Facility Singleton Funeral and Cremation 21. Signatur of Inera Service Licensee M01411 1 2nd Ave. SW, Glen Burnie, MD 21061 Services 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Physician Between Onset and failure. List only one cause on each line. Death Medical a. Cardian galy with atrial and ventricular dilatation Immediate Cause (Final disease -xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed signed by the attending physician and be detached for use as the burial - tran Physician/Medical X UNPENDED AMENDED PII, 27, perME, g877 3/10/08 TT Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE. Year 23b. Was decedent pregnant in the Day Fetal death Month 3 Ectopic pregnancy Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown ð Hypertension, intrathorecic ancient schwannoma Completed 24a. Was an 24b. Were autopsy findings available page 2 should this certificate has been prior to completion of cause of autopsy death? performed? ✓ Yes 2 1 V Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: Residence 6 V Other: Scene Nursing Home 5 ER/Outpatient 3 DOA Inpatient 2 1 V Yes 2 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 1 X Natural Yes 2 No death. Pending Director: 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined within 24 hours a To the Funeral I Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d Date signed (Month, Day, Year) 29b. Signature end title of certifie 29c. License number February 13, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD 32. Ragistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001 OCME 2006

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Fer Du Dry ARS 2008 /Medical 4c. Co aty of Death 4a. Facility Name (If not institution, give street and number) Examiner Nandalls town Know it If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/22/1921 Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 KF Months Days Hours 86 167-12-0036 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6327 GREEN MEADOW PARKWAY 21209 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 🗓 No Saltimore, Maryland 21215-0036 Specify: Completed by 3 X Widowed 4 ☐ Divorced 'natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RENSEL **SCHWARTZ** FREDA ABE 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6327 GREEN MEADOW PARKWAY, BALTIMORE, MD HARRESE DAVIS / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 N Removal from State 02/17/2008 MT. SHARON CEMETERY SPRINGFIELD, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications but caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 🤦 burial-tran Due to (or as a consequence of): the IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ned by tl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Bleed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Dipatient 2 ER/Outpatient 3□ DOA funeral 27. Manner of Dath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 ☐ Pending investigation 1 Natural 1 🗌 Yes 2 Accident within 24 hours after death

To the Funeral Director: completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check on and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cor Lull Br **NEUGU** 32. Registrar's Signature Date filed (Month, Day, State Registrar

08-01271 Ten

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rry Sauer	State of Maryland / Departm	eate of Death	
	For State egistrar . Decedent's Name (First, Middle,Last)	2	Reg. No.  Date of Death  Month  Day  Year  O411 hrs
ledical Examiner	erry Sauer		Month Day Year 0411 hrs February 14, 2008 0411 hrs
	a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Baltimore	To Southly of Bodin
	6010 Eastern Avenue  Social Security Number 6. Sex 7. Age (In yrs. last bli		8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Fore
runeral	. Social deculty Hamber	Months Days Hours Min.	10-24-1960 Maryland
1	219-84-2335 1XM 2F 4/	113.	10d. Inside City Lim
	10a. State 10b. County 10c. City, Town		1 x Yes 2
3 3	MD N/A Bal	timore	10g. Citizen of What Country?
the Maryland a or 28a-f show tified at once.  Director	10e. Street and Number	10f. Zip Code	
death with the Maryland or items 23a or 28a-f sho must be notified at once.	6010 Eastern Avenue	21224  13. Was Decedent of Hispanic Origin? (Spe	USA  scify Yes or No-  14. Race - American Indian, Black,
r death with th or items 23a must be noti	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto I	
	Yes 2 X NO	1 Yes 2 X No specify:	specify: White
nral",	3 Widowed 4 X Divorced If Yes, Give Year or Dates.  15. Decedent's Education (Specify only highest grade completed) 16a	Decedent's Usual Occupation (Give kind of w	ork done 16b. Kind of Business/Industry
2 hour "nate	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use retir	Construction
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exar Completed	12 N/A	Mason Las Mother's Name	(First, Middle, Maiden Surname)
5-0( led wi Hygier other	17. Father's Name (First, Middle, Last)		Wasielewski
121 d be fill ental F arked event,	Edward Sauer  19a. Informant's Name/Relationship (Type, Print )	10b Mailing Address (Street and Number or F	Rural Route Number, City or Town, State, Zip Code)
D 21 should and Me 7 is ma natic ev	Denise Sauer - Sister	3032 Dillon Stree	t Baltimore, MD 21224
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland neat of Health and Mental Hygiene.  ant: If item 27 is marked other than "natural", or items 23a or 28a-f she are other traumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	20a. Method of Disposition 20b. Place	e of Disposition (Name of cemetery, natory or other place)	Date 20c. Location - City or Town, State
lore ges 1 it of H t: If i	1 Burial 2 X Cremation 3 Removal from State	view Crematory 2-1	8-08 Baltimore, MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Nemtal Hygene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner To Be Completed by I	4 Donation 5 Other Specify:	22. Name and Address of Facility V a C	zorowski Funeral Home,
Ba Perm Depa Imp	21. Signature of Euperal Service Licensee  23a. Part I. Enter the disease, or complications that caused the death. Do	1201 Dundalk Av	e. Baltimore, MD 21222
Physician			Between Onset Death
/Medical =xaminer	Immediate Cause (Final disease a. Complications of ch	ronic alcoholism	
Adminer	or condition resulting in death)  Due to (or as a consequence of):		
<u> </u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
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ed nsit	events resulting in death) Last  Due to (or as a consequence or).		
Sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed refearh. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - ransit	X UNPENDED AMENDED 4,27, perME, g8.	77 3/11/08 TT	
60, ste be ex hysician e burial	1/234,2:31	ncy	23d. Date of delivery  Month Day Yea
. Box 68760, the death certificate by the attending physiched for use as the burst clan/Met	23b. Was decedent pregnant in the past 12 months?  1 Live birth Pregnant at time of deat	2 1000000	anty
OX (eath ce atth ce attended for use	1 Yes 2 No 9 Unknown g Unknown		and the second of door
, P.O. Box 68760, res that the death certificate b signed by the attending physical bedeached for use as the but by Dhveiclan/Mere	Part II. Other significant conditions contributing to death but not res	ulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of deat  1 Yes 2 No 3 Probably 4 VUnkr
PO es that the igned by be detac			24a. Was an 24b. Were autopsy findings av
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Division of Vital Records, I tal or Attending Physician: The law requires as after death.  "In Director: After this certificate has been signed in by the funeral director, page 2 should be after a factor of the funeral director. To Do Commisted			1 Yes 2 No 1 Yes 2
tal Recol		26.Place of Death (Chec	
of Vital Fing Physicians After this certificaneral director.	examiner? Hospital: 1 Inpatient 2 E		sing Home 5 Residence 6 ✔ Other: Scene  28d. Describe how injury occurred
of Vit ing Physic After this		28b. Time of Injury 28c. Injury at Work?	28d. Describe now injury costs.
ISION Attendir r death. rector: A by the fu	1 X Natural 5 Pending 2 Accident Investigation		28f. Location (Street and Number or Rural Route Number
ViS or At filter d Direct in by	3 Suicide 6 Could not be 28e. Place of Injury - At hor	me, farm, street, factory, office building, etc.	or Town, State)
Division o spital or Attending tours after death.	4 Homicide (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge	a doubt accurred at the time, date and place, a	nd due to the cause(s) and manner as stated.
		d/or investigation, in my opinion, death occurre	
	(Check only 2 Medical Examiner: On the basis of examination an and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Fear)
To To Com	-1	O.C.M.E.	February 14, 2008
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To with To com	30. Not a and act to serif person who completed cause of death (Item	23a)	
To or To come	30. Nan e and address of person who completed cause of death (Item Pamela E. Southall, MD Assistant Medical Exar	23a)	, MD 21201
To To Common	Pamela E. Southall, MD Assistant Medical Exar	23a) miner 111 Penn Street, Baltimore	, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 2:10 A M FEBRUARY 2008 SMITH **Physician** ETHEL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BACTIMORE RUXTON TOWSON MANOR CARE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) 10.17.1914 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 □ M 2 € **Funeral** Months Yrs. MD 93 Director 212.01.9529 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed withIn 72 hours after death with the Maryland 10b. County 10a, State in then "nature!", or iteme 23e or 28e-f ehow the Medical Examiner must be notified at 1 Yes 2 No Parkville Director Balimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 U.S.A. 3208 Woodhome Avenue Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2전 No If Yes, Give Year or Dates: 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: White Specify: Maryland 21215-0036 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Owner Homemaker permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient important: if I tem 27 ie marked other the gness of place of the fil 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minna Mattes Robert Spangenberger ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 28 Dendron Ct. Parkville, MD 21234 Wayne Smith/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Semation 3 ☐ Removal from State Beltsville, MD 02.15,08 Chesapeake Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, PA 21. Signature of Funeral Service Licenses M01443 8717 Green Pastures Dr. Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition DEMENTIA **Physician** resulting in death) Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed as the burial-transit Exami Due to (or as a consequence of): P.O. Box 68760, the attending physicien Physician/Medical IF FEMALE: 23d. Date of delivery esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ŏ in the past 12 months? 5 ☐ Other (specify) 4 Pregnant at time of death been signed by the a should be detached it 9 Unknown 23e. Did tobacco use contribute to the cause of death? The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Honknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy hes page 2 1 Yes 2 No 2 110 1 ☐ Yes 26. Place of Death (Check only one) or Attending Physician: director. 25. Was case referred to medical examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 ₩o 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To 28d. Describe how injury occurred 28c. funeral 28b. Time of Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) After Division 5 Pending 1 Matural 1 ☐ Yes 2 ☐ No investigation hours after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by the 6 Could not be 3 🗆 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funerel D completely filled in To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number FEBRUARY 2008 14 257722 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEONARD PICHARDSON M.O. 1838 GREENE TREE ROAD #300 PIKESVILLE 31. Date filed (Month, Day, Year) 32. Signature State 2008

DHMH 17 Rev 1/2001

Registrar

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Maryland / Depa	artment of Health and I	Mental Hygie	2000	04728
Dhyoin		Decedent's Name (First, Middle, Last)		-	2. Date of Death Month	Day Year	3. Time of Death
Physic /Medi		Maky		Tuknek	02 13		
Exami	ner	Jams Hopkins	; Hospital	4b. City, Town, or Location of Death  Baltimore, 6  If Under 1 Year   If Under 24 Hrs.	city	4c. County of Dea	thplace (State or Foreign
Funeral Director			1M 2MF 57 Yrs.	Months Days Hours Min.	(Month, Day, Ye	1950 M	OUNTRY)
he Maryland 8a-f ehow cilined all	ector	10a. State 10b. County  M.D. BALTIMORE  10e. Street and Number	10c. City, Town or Lo		100	Citizen of What C	10d. Inside City Limits 1 Yes 2 No
with t	급	608 MONFORD	AUENUE	21215		JSA	,
5-UU36 72 hours after death with the Maryland natural', or Items 23s or 28s-f show dical Examinar must be notified at	by Funeral Director	0-0	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Stif Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi	
Z I Z I D-UUSO ad within 72 hours at giene. er than "natural", or t. the Medical Exam	Completed I	15. Decedent's Edu (Specify only highest grade	cation 16a. Dece e completed) (Give	dent's Usual Occupation kind of work done during most of wor DO NOT use retired) USEWIFE	rking 16	D. Kind of Business	
VIANG 2121  ould be filed within Mental Hygiene.  arked other than '	To Be Co	17. Father's Name (First, Middle, Last)  WILLIAM A	JDREW CARTER	18. Mother's Nar	me (First, Middle, Mai	iden Sumame)	
altimore, Marmin. Pages 1 and 2 sh pertment of Health and portant: If Item 27 ie m portant: If Item 27 ie m y injury or other traum	_	19a. Informant's Name/Relationship (Ty  NCKINLEY TUR  20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens	19b. Mailin 19b. M	matory or other place)  LIFTS REGISTRY Dali  Name and Address of Facility	, BALTIM Date 20 5/2008 HA	ORS MA C. Location - City of ANOVER, N	TOWN, State
<b>n</b> &8558		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death. Do not en	ter the mode of dying, such as cardian			Approximate Interval Between Onset and Death
box 68/60,  death certificete be executed  www.  death certificete be executed  www.  e ettending physician and  dfor use as the buriat-transit	Ilcal Examiner	Immediate Cause (Final disease or condition resulting in death)  Securitary list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last		24 hus 2-3 days			
death certifications of for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of d Month	elivery Day Year
<u> </u>	þ	Part II. Other significant conditions co	ntributing to death but not resulting in the u	<b>a</b>	23e. Did toba		to the cause of death?  Probably 4 □Unknown
The The page	Completed	lungs, liver	e, ventebras	boolises	24a. Was an autopsy performe	d? prior to	autopsy findings available o completion of cause of
Of VICAL Physician: The this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Othor	ath (Check only one)	eo € □Othor (Sr	naciful
on or ting Phy h. After this funeral d	tlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	10 patient 2 ☐ ER/Outpatient	III 3 DOA 4 INdising I	dome 5 ☐ Resident 28d. Describe how		<i>веспу)</i>
or A pictoria	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,		Rural Route Number,
UIVI  To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exami	seciam: To the best of my knowledge, deatiner: On the basis of examination and/or in and manner stated.	th secured at the time, date and plan evestigation, in my opinion, death occ	urred at the time, date	and place, and d	ue to the cause(s)
To the To the comp	2	29b. Signature and title of certifier		29c. License number	1	I. Date signed (Mo.	
$\prec$		Your 13 3. 30. Name and address of person who co	Medizal Poctor completed cause of death (Item 23a) (Type, Cohn H. in H.	L P65 ~ 000	下 (1)	bruary	13, 2008
Si	ate	31. Date filed (Month, Day, Year)	- J	pital LOO N. WO	11- St Ba	ntimal.	MD 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** NELLIE -ebruary 2008 16, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE ATONS VILL FREDERICK VILLA NURSING + REHAB CENTER 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 216-34-4965 Usual Residence of Decedent 1 □ M 2 🗸 F Months Davs MARCH! Director 10c. City, Town or Location 10d. Inside City Limits 10b. County Show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No MARYLAND BAL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 THGRADE ACHI Department of Health and Mental Hygin Important; If Item 27 Is marked other i any Injury or other transcent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be TER ပ္ 19b. Mailing Address (Street and Number or Rural Poute Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JOHN 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 2140 North Fulton Avenue MD21219 21. Signature of Funeral Service Licenses Joseph H. Brown, Jr. Funeral Home Baltimore 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death THRIVE FAILURE Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit and Due to (or as a consequence of) Box 68760 attending physician Physician/Medical as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably Be Completed PRESSURE SKIN VILERS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 certificate has DM 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 ursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Deal After 1 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A death. 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death (Item 23a) Type, Print) NR 0142 516 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 9 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			State of Maryland / Department of Health and N  1- Registrar  Certificate of Death	Mental Hygi	iene 2008 01.730
			Registrar  1. Decedent's Name (First, Middle, Last)	2. Date of Deat	h 3. Time of Death
	Physi /Med	ician dical	PAUL DAVID TILLOTSON	Feb.	14 2008 1:25 PM
	Exam	niner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	11	4c. County of Death
5			GENESIS HEALTH-LOCH RAVEN CENTER BALTIMORE  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	BALTIMORE
8	Funera Directo		176-28-1300 11XIXI 2□F 70 Yrs. Months Days Hours Min.	(Month, Day, NOV 18	
1	pur N		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	NOV. 10	
1/2	Maryla f sho	ē	MADWE AND		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
1	r 28a-	Funeral Director	MARYLAND HARFORD CO ABERDEEN  10e. Street and Number 10f. Zip Code	10	Og. Citizen of What Country?
	th wit 23a o ust be	al D	355 GRACEFORD DR. 21001		U.S.A.
7	er dea tems	nuel	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
3	35 irs aft xamir	by F	1 Never Married 20 Married 1 Neves 2 No		Specify: WHITE
9	5-0036 72 hours aftinatural", or dical Exami	Completed by	15. Decedent's Education 16a. Decedent's Usual Occupation	. 1	6b. Kind of Business/Industry
- 7	ithin 7	nple	(Specify only highest grade completed)  [Give kind of work done during most of work life. DO NOT use retired)  [Give kind of work done during most of work life. DO NOT use retired)	king	·
	d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified ≝t	S			U.S. ARMY
	ld be lid be ental ked o	To Be	RUBERT TILLOTSON	e <i>(First, Middle, M</i> SMI'	,
	More, IMaryland 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. nt: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show ny or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Run		
	and 2 and 2 lealth m 27 I		Mary I. Tillotson/Wife 355 Graceford Dr., Ab		Md., 21001
	SAITIMORE, bermit. Pages 1 ar Department of Hea mportant: If them iny lnjury or othe		1 ☐ Burial 2XX remation 3 ☐ Removal from State cemetery, crematory or other place)	Date 2	Oc. Location - City or Town, State
-	트 노토병을	a	4 □ Donation 5 □ Other (Specify) METRO CREMATORY 02-1  21. Sign 1/2 of Funeral Service Licensee 22. Name and Address of Facility	5-08 B	ALTIMORE, MARYLAND
c	Depa Impo	5	MILLIAM C BROWN COL 321 S PHILADELPHIA	MM FUNERA	AL HOME-HARFORD, P.A.
	1965		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.	or respiratory arres	st, Approximate Interval Between
	Physician	_	Immediate Cause (Final disease or condition		Onset and Death
	/Medical Examiner		Due to (or as a consequence of PNLUmm Na		
		<u>ē</u>	Sequentially list conditions,		
	xecuted and Il-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.		
C C	o / oU, rate be executed hysician and the burial-transit	EX	resulting in death) Last  Due to (or as a consequence of):		
207	icate l	dical	d		
3	Hospital or Attending Physician: The law requires that the death certificate be executed 4 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy		23d. Date of delivery
	deatle he atte	sicia	in the past 12 months?  1 ☐ Yes 2 ☐ No  1 ☐ Yes 2 ☐ No		Month Day Year
	uires that the de signed by the a d be detached f	Phy	9 ☐ Unknown  Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	00 Billi	
Od abroad lettive or view	uires t signe	d by	, and its significant contained in Part is		acco use contribute to the cause of death?  S 2 □ No 3 □ Probably 4 ☑ Unknown
Š	aw requir s been si s should I	lete		24a. Was an	
ď	The lav	Completed		autopsy perform 1 Yes 2	prior to completion of cause of death?
/its	vicar: The sician: The certificate rector, pag	Be	25. Was case referred to medical examiner? 26. Place of Death		
į	Physic this c	일	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hol 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		nce 6 □Other (Specify)
2	nding F th. :: After e funera	tion	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation  28a. Date of Injury (Month, Day Year) 28b. Time of Injury 4 Injury 8 Injury 9 Injury 1 ☐ Yes 2 ☐ No	28d. Describe how	v injury accurred
	r Atter	Certification:	3 Suicide 6 Could not be	28f. Location (Stre City or Town,	pet and Number or Rural Route Number,
Ē	oital o urs aft eral Di	Cer			
	To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place, and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.	and due to the cau red at the time, dat	use(s) and manner as stated. te and place, and due to the cause(s)
	To th Withii To th	M	29b. Signature and title of certifier 29c. License number		d. Date signed (Month, Day, Year)
			30. Name and address of person who completed gause of death (Item 23a) (Type, Pript)	2 F	eb. 142008 more 21204
	11		100 2004 6701 N.Charles 57. 4202	Balti	more 2/204
	St Regist	ate trar	31. Date filed (Month, Day, Year) 32 Registrar's Signature		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 11:04 AM February 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BATTIME ( HEJOHNS HOPKINS Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Min 619-1do-460 1**□**-M 2□ F **Director** Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location r then "neturel", or Items 23s or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ 100 Completed by Funeral Director Hawthorne 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Lndonesia 9Dasi 4626 Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 2 □ Ne If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Ne-Asian Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12+1 Employeed lechiciqu other or other treumetic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other treumetic event size. Be 130 Paen Chung BONG 19a. Informant's Name/Relationship (Type, Print) 4626 Broadway Hawthome CA 90251 WEI 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/23/2008 Baltimore, MI Greenmount Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address Facility Joseph C. Orecre French Services 21. Signature of Funeral Service Licensee · Kun 4405 York And Baltimore, MD 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** months /Medical Due to (dras a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Diseese or injury that initiated events Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA : After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of D ath 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation after death filled in by the 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a To the Funerel [ Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Celler 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street North 600 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 9 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day AWRENCE THOMPSON FEBEUARY 16 /Medical 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL CENTER Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Days Hours 216-52-0338 55 03-11-1952 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show must be notified at MD BALTIMORE TURNER STATION 1 ☐Yes 2 ☐ No Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 127 CARVER ROAD 21222 USA Funeral death items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ☐Yes 2 Yes, Give 1 Never Married 2 Married o, Baltimore, Maryland 21215-0036 1 ☐ Yes 2 █No Completed by Specify. Specify BLACK 3 Widowed 4 □ Divorced Year or Dates 'natural' 7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 DELIVERY TRUCK DRIVER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental H LAWRENCE THOMPSON, SR. MARGUERITE SMITH ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AGNES M. HOLMES/SISTER 2311 RUTH AVENUE, EDGEMERE, MD 21219 Item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of important: If it any injury or conce. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE CEM. 02-20-2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H. INC 21. Signature of Funeral Service Licensee 1701 LAUREENS ST., BALTIMORE, MD 21217 wolon 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COPD Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events burial-trai resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1X Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performe 1∐ Yes 25. Was case referred to medical examiner?
1) Yes 2 No Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: Certification: To 2 KER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending investigation Injury after death. 1 Tes 2 No the 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a To the Funeral I Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0004878 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JHBMC 4940 Eastern Avenu Baltimor, MP south na

Registrar

State

2. Registrar's Signature

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ral", or Items 23a or 28a-f sh Examiner must be notified

"natural",

al Hygiene.

f Health and Menta item 27 Is marked

permit. Pages Department of Important: If it any Injury or o

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Director

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

and attending physician as the use jo the þ signed has certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

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Certification;

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The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

Examiner Physician/Medical þ Completed 25. Was case referred to medical examiner? Other: 42 Nursing Home 5 Residence 6 Other (Specity) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

D44156

3110 Grace field Rd Silver Spring

2/13/2008

31. Date filed (Month, Day, Year) State Registrar

Rachelle

Kachelle alexon NO

Alexion

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

2. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Burne

ORIGINAL

		Please Type or Pri						ole.
		State of M	laryland / Depa			Mental Hy	giene 2 []	08 04735
	0	Registrar  1. Decedent's Name (First, Middle, Last)	Ce	rtificate of D	eath		Reg. No.	
Physici /Medi		Marsha White				2. Date of De Month	//5/2c	Year 6.45 PM
Examir	ner	4a. Facility Name (If not institution, give street and number, Stella Wari S	)	4b. City, Town, or L	ocation of Deat	h M	4c. County of	of Peath  I Move
Funeral Director		219-58-6294 10M 2/1F	ge (In yrs. last birthday) 54 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th y, Year) 1953	9. Birthplace (State or Foreign Country)
laryland show ed at	o.	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
death with the Maryland ms 23a or 28a-f show r must be notified at	Director	10e. Street and Number	Pagel	10f. Zip Code			10g. Citizen of W	
death v	Funeral	11. Marital Status 12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hisr	AD panic Origin? (S	Specify Yes or No	u S	- American Indian,
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permit. Pages 1 and 2 should be filled within 72 hours after death with the Man Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f st any injury or other traumatic event, the Medical Examiner must be notified once.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or	O+)	kind of work done dui DO NOT use retired)	ring most of wo. A Lev	rking -	Life I	Insurance Co.
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mit. P. partme portant / Injury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	1 King H	2. Name and Address	of Facility V	auchn	C. Cres	Mere MAS
permi Depa Impo any ir		Daugh (. M	8	728 Lil	perty "	Rd. P	andalos	ton, mozus
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** February Wellmaker /Medical 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location Baltimore City, Town, or Location of Death Examiner 4c. County of Death **Funeral** 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign Hours 1□M 2XF Days Min. Director jeorgia 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Examiner must be notified at Md. Director 1 Yes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 233 13. Was Decedent of Hisparlic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📜 No Completed by Specify: 3 X Widowed 4 □ Divorced Blac event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) condary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၟႄ Important: If item 27 is marke any injury or other traumatic Informant's Name/Relationship (Type. Print) [daughter] 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) treeman 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State Mem. Pa 4 Donation 5 ☐ Other (Specify) P. Name and Address of Facility 21. Signalure of Funeral Service/Licensee Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Part LEnter the dishort, or heart fail Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) Arterioscleratio Vascular Due to (or as a consequence of): nkmown /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: death certificate be executed as the burial-tran Due to (or as a consequence of): Box 68760. signed by the attending physiciar Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
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1 ☐ Yes 2 ☐ No has autopsy performe 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director; After this 28a. Date of Injury (Month, Day Year) 27. Manner of eath Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who competed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Agres / 32. Registrar's Signature. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** M elli 04 45 PM Feb 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Agnes Hospital Baltimore Saint NIA If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 💢 F Hours 218-26-550 1422, 1933 Director maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fulury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Xyes 2 □ No Funeral Director imore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Apt. 313 12. Was Decedent Ever in U.S. Armed Forces? 1 Deceder 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed by 3 ☐ Widowed Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) ranspor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ပ 19b. Mailing Address (Street and Number or Rural Ro te Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) to, md, 21229 5 frederic 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation rematur 4 Donation 5 ☐ Other (Specify) 21. Signature & Funeral Service Lie 22. Name and Address of Facility md.21229 23a. Part1 prer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease or condition resulting in death) **Physician** clostrid Days /Medical Due to (or as a consequence of) Examiner Rena Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be execute stroke Atno M. the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform this certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred A fter 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours a er death To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide 29a. Certifier 1 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Feb, 11, 2008 MD 120655

DHMH 17 Rev 1/2001

State

Registrar

900

32. Registrar's Signature

caton

Ballimore

MD

21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mohammad

31. Date filed (Month, Day, Year) FEB 1 9 2008

FEB

Valikhani

Mark Charles Winterling

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 04738

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5-0036 led within 7 Hygiene. I other than the Medica	5	17. Father's Name (First, Middle	e, Last)						s Name (F	First, Middle		en Surname)			_
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2121 ould be fi ! Mental ] s marked ic event,	2	19a. Informant's Name/Relations	ship (Type, Print )		19b. Mail	ing A	ddress (Street					City or Town	, State,	Zip Code)	-
MD d 2 sho tth and n 27 is numati		Patsy Winterl	ing, Mother		4821	Há	azelwood	! Ave	enue	Balti	more	e, Mar	yla:	nd 21206	
		20a. Method of Disposition	n 3 Removal from Star	20b.		ositio	n (Name of ceme			Date		c. Location -			_
altimore, mit. Pages l ar partment of He portant: If ite ury or other tr		1 Burial 2 X Cremation 4 Donation 5 Other S	-		-		atory In	nc.	02/	15/08	1	Baltim	ore	, Maryland	
Baltin permit. P Departme Importan injury or		21. Signature of Funeral Service	nsee				-								_
E E E E	_	Thomas Gregor	- Constitution		12	ger 99	nation S Frederi	ocie .ck R	ety O Road	u Mar Balti	y Lai nore	nd, In e. Mar	c. vla	nd 21228	
Physician		23a. Part I. Enter the disease, or failure. List only one cause		he death	. Do not ente	r the	mode of dying, su	uch as ca	ardiac or r	espiratory a	rrest, s	hock, or hea	rt rt	Approximate Interval	
/Medical :aminer	ì	Immediate Cause (Final disease		morrha	ige								i	Between Onset and Death	
anime		or condition resulting in death)	Due to (or as a conse												_
	<u>.</u>	Sequentially list conditions,	b												
	ine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consec	quence o	of):									,	
W	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	quence o	of):										_
cuted			d												
law requires that the death certificate be executed has been signed by the attending physician and 2 should be detached for use as the burial - transit	n/Medical	UNPENDED	AMENDED												
8760, tificate be ng physic as the bur	Ne Ne	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	e of preg				_			2	23d. Date of	delivery		-
68 certif	ä	past 12 months?	1 Live birth  Pregnant at t	me of de	2			Ectopic	pregnand	СУ		Month	D	ay Year	
Box e death c the atten	ysicia	1 Yes 2 No 9 Uni			eath 5	Other	(Specify)				1				
that the death certiff ned by the attending detached for use as I	Phy	Part II. Other significant condit	tions contributing to death	but not re	esulting in the	und	erlying cause giv	en in Par	rt I.	23e. Did	tobacc	o use contrib	oute to t	he cause of death?	-
ires that to signed by the detaction	d b	Chronic Alcoholism								1 Y	es 2	No 3	<b>∕</b> Proba	ably 4 Unknown	
ords,  » requir s been s should I	eţe								-	24a. Wa	s an			opsy findings available	e
e law e has	Completed								_	auto perf	opsy ormed	? pr	ior to co eath?	ompletion of cause of	
tal Rection: The	8	25. Was case referred to medica					00.51	5 m	<u> </u>	1 Yes	2	No 1	<b>✓</b> Yes	s 2 No	_
Vital ysician: his certif director,	Be	examiner?	Hospital	2 2	ER/Outpatie	nt 2	26.Place o	thor:			Desi	d C	]Other in		_
	£	1 ✓ Yes 2 No 27. Manner of Death	- Impation		28b. Time o					Home 5		dence 6	Other:	·	_
nding th.	틸	1 V Natural 5 Pend	28a. Date of Injury (Month, Day, Ye	ar)			1 Ye			ou. Dosciibe	711011	njury occurre	_		
isic Atter or dea rector	اق ا	2 Accident Inves	stigation 290 Place of Inju	rv - At ho	ome farm str	eet f				8f Location	(Street	and Number	r or Pur	al Route Number, City	_
Div tal or rs afte	Certification:	deter	d not be (Specify)	., , ,,,,,,	ome, rarri, ea	000,	dotory, omeo ban	onig, oto	. [2	or Town,		and Numbe	OI IXUI	ar Notice Number, City	
Division of 1 To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral		29a. Certifier 1 Certifying Pl	hysician: To the best of my	knowledd	ne death occ	urrad	at the time date	and place	co. and di	ue to the cer	100(0)	and manner			-
the I the I the I	Medical		miner:On the basis of exam												
7 W. T. O. O. O. O. O. O. O. O. O. O. O. O. O.	ğ	29b. Signature and title of certifie	and manner stated.	•			29c. License r	number		···-	29 d	I. Date signe	d (Mon	th, Day, Year)	_
		/ Canto	So MI				O.C.M.	.E.				bruary 5,			
\	-	30. Name and address of person	who completed forms of the	ath /Itam	1232)										_
\			ssistant Medical Exar	,	,	ın Si	treet, Baltimo	ore, ME	21201	1					
St	ate	31. Date filed (Month, Day, Year)	32, Registrar's					,				-			_
Regist		FEB 1 9	2008	9	Ace	u A	300								
DHMH 17 Rev 1/20	01	00115			ORIGIN	AL.								<del></del> = \	_

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 04739

		1- For State Cert	tificate of Death		Re	g. No.	
Physici Medical Exami		Decedent's Name (First, Middle,Last)     Michelle	Whi	tehead	2. Date of Death Month February 1		3. Time of Death 2146 hrs
¥		4a. Facility Name (if not institution, give street and number)  Johns Hopkins Bayview Medical Center	4b. City, Town Baltimore	, or Location o		4c. County of Deat	n N/A
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. la 215-02-8513 1 M 2XF 35		Year If Under Days Hours	Min. Oct.	h(MM/DD/YYYY) 9. Bi Forei 5,1972	
эм апу			Town or Location				10d. Inside City Limits 1 Yes 2 X No
Maryland Maryland  28a-f shu d at once	Director	Maryland Baltimore  10e. Street and Number	Dunda 10f. Zip Coo	le	10	og. Citizen of What Cou	
death with the Maryland or items 23a or 28a-f sho must be notified at once.		7922 Stratman Road  11. Marital Status  12. Was Decedent Ever in U.: Armed Forces?	S. 13. Was Decedent of	21222 Hispanic Original	in? ( Specify Yes or No- Puerto Rican, etc.)	United St	rican Indian, Black,
	by Funeral	3 Widowed 4 XXDivorced If Yes, Give Year or Dates:	1 Yes 2 X	No specify:		Specify:	White
7 3 -	Completed t	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	16a. Decedent's Usual Occiduring most of working	life. DO NOT u	use retired)	16b. Kind of Business State of	/Industry
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umatic event, the <u>Medica</u>	Somp	12 Years 17. Father's Name (First, Middle, Last)	Correction		1.Cer s Name (First, Middle, N	Maryland Maiden Surname)	
1215 be file ental Hy rrked o	Be	David H. Rogers			ıra J. Aire	-	
imore, MD 21215 Pages I and 2 should be filt ment of Health and Mental H smit. If item 27 is marked t or other traumatic event, 1.	P	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (S			-	
e, M I and 2 Health item 2			Place of Disposition (Name or		ace Abingdo Date	n , MD 210	
MOF Pages ent of nnt: If		r 25 Demai 2 Gremation 5 Nemoval nom State	rematory or other place)  Stanislaus	Cem.	2/21/2008	Baltimor	e, Maryland
Baltimore, permit. Pages I an Department of Hea Important: If iter		21. Signature of Funeral Service Licensee	22. Name and Add	ress of Facility			
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death, failure. List only one cause on each line.	Do not enter the mode of dy	ing, such as ca	ardiac or respiratory arre		Approximate Interval Between Onset and
vaminer		Immediate Cause (Final disease or condition resulting in death)  a. Curplications of Due to (or as a consequence of		abetes m	ellitus		Death
	_	Sequentially list conditions,  If any, leading to immediate  b	n.				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated					
cuted nd Iransit		events resulting in death) Last  Due to (or as a consequence of d.	7):				
760, ricate be executed physician and the burial - transit	/Medical	X UNPENDED #Z3,27,perMEg87					
688 ertif		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregr 1 Live birth 4 Pregnant at time of dea	2 Fetal death	3 Ectopic	pregnancy	23d. Date of delive Month	ry Day Year
Box he death c the atten hed for us	Physician	1 Yes 2 No 9 V Unknown g Unknown			22a Dida	bacco use contribute to	the same of death?
ires that the d	Completed by F	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cau	se given in Pai			obably 4 Unknown
of Vital Records,  g Physician: The law require ther this certificate has been si neral director, page 2 should b	plete				24a. Was a autop perfor	sy prior to	utopsy findings available completion of cause of
	So			(D	1 ✔ Yes		
Vital I hysician: this certifi ul director,	o Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓	ER/Outpatient 3 DOA	Other	Check only one)  Nursing Home 5	Residence 6 Oth	er:
- # ^ e	$\vdash$	27. Manner of Death 28a. Date of Injury (Month, Day, Year)		Injury at Work		now injury occurred	
Division pital or Attendious after death teral Director: A	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	ome, farm, street, factory, offi	ce building, etc	c. 28f. Location (S or Town, S		tural Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical C	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination are and manner stated.					
Z : Z : S	Me	29b. Signature and title of certifier		ense number		29d. Date signed (M	
	Į	Carde Hallan		C.M.E.		February 16, 20	08
(15)		30. Name and address of person who completed cause of death (Item Carol Allan, MD Assistant Medical Examiner	23a) 111 Penn Street, Balt	imore, MD	21201		
		31. Date filed (Month, Day, Year) 32. Registrar's Signatur	re /				
Regist	rar	TER 1 9 2008 At a con 65 a	Sparke				

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 04740

			For State			Cei	tificate c	of L	Death					Reg. N	lo		1 0 Time	a of Dooth
	Physicia		. Decedent's Name (First, Midd	e,Last)							2.	Date of Dea	ath Da	v Ye	ear		e of Death	
le i	ור Examin		Murano			J.			Wi	lki	ns	1	Month Day Year 1549 hrs February 11, 2008					49 N/S
49	LACITO		Tyrone la. Facility Name (if not institution	n give stre	eet and nu			4b	. City, To			Death			4c. Count			
			Northwest Hospital	,,, g.,, o		,			Randa	llstown	ı			- 1	Baltimo	ore Cou	unty	
		4				7 A = - (In	ant hirthday)	1	If Under	1 Year	If Under	24Hrs.	8. Date of B	Birth(MM/DD/YYYY) 9. Birthplace (State or				
	<b>Funeral</b>	5	5. Social Security Number	6. Sex		7. Age (In yrs. I	ast birtinday)	Months Days Hours Min.								Forei	gn ountry)	
	Director		219-74-8622	1 <b>X</b> M	2 F	49	Y	rs.		'			01 (	<u> </u>	59		Juliu y )	NJ
		h	Usual Residence of Decedent														104	nside City Limits
	any		10a. State 10b. County				, Town or Loc											
	ž ,	-	MD N.	A			Balti	mo	ore								1 2	Yes 2 No
	Maryland 28a-f show d at once.	황						$\neg$	10f. Zip (	Code				10g.	Citizen of	What Cou	intry?	
	death with the Maryland or items 23a or 28a-f sho must be notified at once.	ခို	10e. Street and Number				" 400	-	,		201		ľ		11	.s.A		ŀ
	the a or	E	124 West Fr					┙							-	-		dian, Black,
	with th	Funeral	11. Marital Status	12	. Was Dec	cedent Ever in U	J.S. 13. \	Was	Deceden	nt of Hisp	anic Origi Mexican.	in? ( Spec Puerto R	cify Yes or Nican, etc.)	<b>N</b> 0-		hite, etc.	ilicali ili	ulari, bidok,
	iten iten	12	1 Never Married 2 X	Married	Yes	2X No			э, ороон,	0000	,				1	F	Blac	:k
	ler de		3 Widowed 4 Di	vorced If Y	as, Giva Yea		1		Yes 2X	No	specify:				Specif	y:		
	rs af ural	좡	15. Decedent's Education (Sp	ecify only h	Dates: ighest gra	de completed)	16a. Deced	dent'	's Usual C	Occupation	on (Give k	kind of wo	rk done	1€	b. Kind of	Business	/Industr	У
	hou hou Exa	Completed	Elementary/Secondary (0-12			1-4 or 5+)		_	st of work			use retire	ia)	- 1	0-	h 00		
	36 n 72 n 72 lien	읦	12th grade		na		Ca	ıb	Dri	.ver					Ça.	b Cc	סמוועכ	illy
	with iene	티	17. Father's Name (First, Middle	a Loct)						1	8.Mother	's Name (	First, Middle	e, Mai	den Surna	me)		
	Hyg toth		Willie W.Wi		C							y Sy						
	21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner	8					10h Mai	ilina	Address				ıral Route N	lumbe	r. City or 7	Town, Sta	te, Zip (	Code)
	, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tent 27 is marked other than "natural", or items 23a or 28a-f she tranmatic event, the Mediral Examiner must be notified at once	잍	19a. Informant's Name/Relation	iship (Type	, Print )	h a 10	1 2 /	1 1	Most	· Fr	ank	lin	St.	Ap	t 40	3, E	3ali	timere
	MD 2 shot allth and a 27 is aumatic	- 1	Mary M. Wil	kins	-Mot	ner				_			Date	12	Oc. Locati	ion - City	or Town	State
	imore, MD 2 Pages I and 2 shou nent of Health and N ant: If item 27 is n or other traumatic	Ш	20a. Method of Disposition				. Place of Dis	r oth	er place)									
	MOFE Pages 1 nent of H ant: If i	ш	1 X Burial 2 Cremati		Removal f	from State	mpsor	1	U.M.	. Ch	urc	h 2/	18/0	8	Mt.	Aiı	cy,	Md
	Pag men tant	1.	4 Donation 5 Other	Specify:	1									_				
	Baltimore, permit. Pages 1 at Department of Het Important: If ite injury or other tr	1	ig ture of Funeral Service	e License	1.04	MI	Į Ņ	/a`	rch	F/H	We	St Aug	Bal	+ i ·	more	, Mo	3	21215
	<b>™</b> % ∆ ⊆ .≡		23a Part I. Enter the disease,	( ) ( )	WA	14		43	00 V	vaba	SII .	AVE /	respiratory	arrest	t. shock, or	r heart		proximate Interval
	hysician		23a Part I. Enter the disease, failure. List only one caus	or complica se on each	tions thet	caused the dea	th. Do not ent	er u	ie mode c	of dying,	30011 43 0	zardido or	1000		,		Be	etween Onset and Death
+	Viedical	1	mmediate Cause (Final disease	Dil	ateral p	ulmonary th	romboeml	boli									_	
	_xaminer	V	or condition resulting in death)			a consequence												
		- 1	C Call that any distance	b.													-	
		5 E	Sequentially list conditions, if any, leading to immediate		e to (or as	a consequence	of):											
		Examiner	cause. Enter Underlying Caus (Disease or injury that initiated	U											_		-	
		ğ	events resulting in death) Las		e to (or as	a consequence	of):											
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	exectan a	is	UNPENDED		AMENDED	)											$\perp$	
	760, ficate be g physicist the buri	//Medical	IF FEMALE:		23c. If yes	s, outcome of pr	egnancy									ite of deliv	-	V
	976 ifica ig ph	5	23b. Was decedent pregnant in		1 Live	e birth	2	Fe	etal death	3	Ectop	ic pregna	incy		Mon	nth	Day	Year
	cert use a	cia	past 12 months?	î	4 Pre	gnant at time of	death 5	01	ther (Spe	ecify)				_	1			
	303 leath	Physiciar	1 Yes 2 No 9	Jnknown	-	nown									<u></u>			of dooth?
	the of	ద	Part II. Other significant con	ditions c	ontributing	to death but no	t resulting in	the	underlying	g cause (	given in P	Part I.						cause of death?
	that	þ											1	Yes	2 No	3F	Probably	4 🗸 Unknown
	S, C	eq											24a. V			24b. Were	autops	y findings available
	rd v req	jet												autops erforn		prior deati		oletion of cause of
	e lav e has ge 2 :	Completed												es 2		1 🗸	Yes	2 No
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial. Transit		25. Was case referred to med	ical						26.Plac	e of Deatl	h (Check	only one)					
	cian certi	Be	examiner?		spital:	Inpatient 2	✓ ER/Outpa	atien	t 3	DOA	Other <sub>4</sub>	Nursir	ng Home 5	5 🔲 F	Residence	6 O	ther:	
	F Si Si Si Si Si Si Si Si Si Si Si Si Si		1 ✓ Yes 2 No				28b. Tim				ıry at Wo		28d. Desc		ow injury o	occurred		
	of ng P After unera	Certification: To	27. Manner of Death		(Mo	ate of Injury onth, Day,Year)	200. 11111	ic 0,	ii ijoi y		Yes 2							
	endi ath.	ıtio		ending vestigation	,											Numbero	r Dural	Route Number, City
	r Att er de irect	fica		ould not be	28e Pl	lace of Injury - A	t home, farm,	, stre	eet, factor	ry, office	building,	etc.	28f. Locat or To	wn, St	treet and rate)	Number o	Ruiai	reduce reduiber, only
	S aff	Ť		etermined	(Speci	ify)												
	Divis Hospital or / 24 hours after Funeral Dire		20- C-stiffer	Physicia	n: To the h	best of my know	ledge, death	occı	urred at th	ne time, o	date and p	place, and	d due to the	cause	e(s) and m	anner as	stated.	4.
	To the Hos within 24 ho To the Fun completely	Medical	(Check only one) 2 Medical E	xaminer:	On the bas	sis of examination	n and/or inve	estiga	ation, in n	ny opinio	n, death	occurred	at the time,	date a	and place,	and due	to the ca	ause(s)
	To the within 2 To the complete	ed			and manne	er stated.		_			se numbe				29d. Date	e signed	(Month,	Day, Year)
4		Σ	29b. Signature and title of cer	uner A	1	021					.M.E.				Februa	ary 12,	2008	
1			Bush	0/	jes	X MAD				0.0						,,		
	1		30. Name and address of per	son who co	ompleted d	e of death (	tem 23a)		1.4	-								
	L .		Tasha Greenberg N		ssistant	Medical Ex	aminer	111	1 Penn	Street	, Baltim	nore, M	D 21201					
		,,,				277		A STATE OF THE PARTY OF THE PAR	BAK	1								
	- 5	tate		['9 20	108	. Registrar's Sig	S.50		All or other transmission of									
	Regis	tra	1 h. L.		100			45										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>008</u> **Physician** Month 5:35pM Robert O. Walters Feb.14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 311 Capitol Court Essex Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug16, 1928 Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days 1√2 M 2□ F 220-24-1646 79 Director Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show "natural", or items 23a or 28a-f shovidical Examiner must be notified at Baltimore MD Essex 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with tent of Health and Mental Hygiene.

Interest of Health and Mental Hygiene.

Interest is marked other than "natural", or items 23a or 2 and 2 311 Capitol Court 21221 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify. 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) National Wire Forklift Operator 5th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Walters ဂ္ Agusta Wilkinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Huovinen /daughter 90 West Kingston Park Lane Balto MD 21220 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If Itel any injury or otl once. Holly Hill Cemetery 2/18/08 Baltimore MD 2 □ Cremation 3 □ Removal from State 1X Burial 4 □ Dona# 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD Funeral Skrvice Livensee 21. Signatur Connelly Funeral Home of Essex Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one sause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic **Physician** una Concei month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consequence of be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autonsy performed? /es 2 No 1∏ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Box 68760, P.O. Division or Vital Records,

State

Medical

(Check only one)

HSTIKAN

31. Date filed (Month, Day,

29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D54841

29d. Date signed (Month, Day, Year)

15/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 🛴 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Winifred White FEBRUARY 12, 2008 17:24 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b-City, Town, or Location of Death Ac. County of Death Examiner BALTMORE 1.65 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 080-14-8742 88 Months Days Hours Min 1 M 2 K Director 11/30/1919 NY Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at NY Kings Brooklyn 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 325 Clinton Avenue (#11-B) 11205 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or iter any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Black þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Elementary/Secondary (0-12) College (1-4or 5+) Clerical Worker Social Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Henry White, Sr. Edith Ricks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 18 - Box 6040; Frutchey Drive, East Stroudsburg, John H. White, Jr. PA 18302 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Rosehill Cemetery 2/21/2008 Linden, NJ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Charles L. Stevens Funeral Home Inc. sometor 1501 East Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE TULMONARY hours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 🔲 Yes 2 No 3 Probably 4 Unknown Be Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Division or Vital 2 No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 10X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) eimi Duyilin D 22 C YF Fobruary 12, 2008

State Registrar Jerome I

31. Date filed (Month, Day, Year)

900 SOUTH CATON AVENUE BALTIMORE, MARYLAND 32. Colstra's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SNYDER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 5 Month **Physician** 6:05 AM Earle F. Wisner ,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Keswick MultiCare Center Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 213-16-5090 14√3 M 2 □ F 88 12-20-1919 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10b. County show 10d. Inside City Limits r 28a-f show notified at 1 XX es 2 □ No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe d 700 W. 40th Street 21211 r than "natural", or items 23a the Medical Examiner must b USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc Yes 2 No Yes, Give Year or Dates: WWII 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify Completed by 3 ☐ Widowed 4 ☑ Vivorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer Public Works permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 Is marked other t any Injury or other traumatic event, <u>th</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Howard Wisner 2 Lubina Hammond 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard A. Wisner Son 5 Foreston Valley Court Parkton, Maryland 21120 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XXurial 2 ☐ Cremation 3 ☐ Removal from State Important: If any Injury or once. New Cathedral Cemetery 2/19/08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. 21. Signatur of Funeral S 3631 Falls Road Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only or cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End the Cerebrowasenlar disease **Physician** earsdisease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events burial-tra resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by anterinscleration Superfeasure heart disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown huth uschemic 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an 1∏ Yes 2 No 25. Was case referred to redical examiner?

1 Yes 2 No completely filled in by the funeral director, Be 26. Place o ath Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2710 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 15,2008 M. Dankelle 013657

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

ORIGINAL

TI PRABELLE TIMESREGOR, 700 W. YOK STREET, BALTIMORE, OF 21211

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #18, perFH, g876, 2/28/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** February 470: Alma Catherine Warner 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner wons 1timore If Under 24 Hrs. 8. Date of Birth (Month, Day, SEP 28, If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 □ XF Months Days 94 1913 Maryland Director 220-14-0042 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No Catonsville Baltimore Director Marvland 10g. Citizen of What Country? USA 10e. Street and Number 10f. Zip Code 21228 709 Maiden Choice Lane RGS405 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗓 No Specify: Specify: þ 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4or 5+) \$pringfield State Hosp. Food Service 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) d 2 should be finith and Mental H Be Annie Hanschuh Anna Handschuh permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evance. Edward Foster 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 47 Pine Vale Road Waltham, MA 02451 <u>Bernice Vonsaleski/d</u>aughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State New Oakland Cemetery 02/16/2008 Sykesville, MD 4 Donation 5 Other (Specify) Haight Funeral Home and Chapel, P.A. P.O. Box 195 Sykesville, MD 21784 (410-795-1400) 21. Signature of Funeral Service Licensee Mand mc Brand Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** hronic ear /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the huria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) detached f 1 Yes 2 No 9☐Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an has autopsy performed? Yes 2 No page certificate 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Desire 1 Residence 6 Other (Specify) 1 ☐ Yes 2 N 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No М after death 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and hitle of certifie 0 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Maiden hi

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

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9 2008

32. Registrar's Signature

08-01056 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 Bernestine Wallis State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day February 6, 2008 0950 hrs **Medical Examiner** Bernasteine Wallace 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** 3905 Edgewood Road, Apt. # 230 If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Davs Director MD 215.78.0257 49 01.29.1959 1 M 2 XF Yrs. Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 Yes 2 No "natural", or items 23a or 28a-f show Examiner must be notified at once. N/A MD Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3905 Edgewood Rd. Apt. U.S.A. 21215 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes Black If Yes, Give Year 3 Widowed Yes 2 No specify: Specify. 4 Divorced "natural". ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry imore, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours nent of Health and Mental Hygiene. Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) event, the Medical 2 Home Maker Own Home tem 27 is marked other traumatic event, the Me 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Wallace Mary Hopes (Street and Number or Rural Route Number, City or Town, State, Zip Code)
21217 19a. Informant's Name/Relationship (Type, Print ) Jessica Jo<u>rdan/daughter</u> Fulton Ave. Balto Apt. item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 02.12.08 Beltsville, MD mportant Chesapeake Crem. Donation 5 Other Specify 22. Name and Address of Facilit CAFA/Stephen D. LohrmannPA 21-Signature of Funeral Service Licensee MO1443 8717 Green Pastures Dr. Balto. Approximate Interval 23a. Par I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line. Between Onset and /Medical Death Atheosclerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and led for use as the burial - transit Physician/Medical X UNPENDED Division of Vital Records, P.O. Box 68760, the Hospital or Altending Physician: The law requires that the death certificate be hin 24 hours after death. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown icate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Diabetes mellitus Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 1 🗸 Yes 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: Other<sub>4</sub> examiner? Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 this 1 V Yes No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 1 Yes 2 No neral Director: / filled in by the f Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f, Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) 24 hours a determined 4 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 3 one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. February 7, 2008

Och

State 31. Date filed (Month, Day, Year)
Registrar

32. Signature

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

OF VE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** tebruary /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Health + Reha Birthplace (State or Foreign Age (In yrs. last birthday) Security Number 6. Sex **Funeral** Hours Min. Days Months 1 □ M 2 👿 F 239-32-6655 Usual Residence of Decedent Director 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at 1 XYes 2 □ No Funeral Director timore 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number ral", or Items 23a or Examiner must be r USA

14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married "natural", or 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Completed by 3X Widowed 4 □ Divorced lac 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life\_DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation ortant: if ii Injury or 3 □Removal from State Important: if any Injury or once. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Joseph L. Rus 2222 W. North 21. Signature of Funeral Service License reral P.A Home Ave. Balto. 23a. Phril. Enter the risease, or complications that so used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, it, or heart filure. List only one cause on each line. Approximate Interval Between Onset and Death Imme ate Cause (Final to thinve Physician milline disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Deliudiation Sequentially list conditions, if any, leading to infine flat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical signed by the attending I IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 4☐Pregnant at time of death 9 Unknows Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Demen 10 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 page 2 certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 20 No Other: 4☐ Nursing Home 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA 5 ☐ Residence 6 ☐ Other (Specify) 2 After this 27. Manner of Cath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury Natural 2 Accident 5 Pending investigation М 1 □ Yes 2 □ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature 31. Date filed (Month, Day, Year) State 9 FEB

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🎧 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Maggie Cleo Yancey **Physician** ebonary 10:44AM 2008 /Medical 15 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Med. Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) North Carolina 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F Months 244-60-2003 Director 76 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at MD Anne Arundel Hanover 1 □Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1492 Dorsey Road 21076 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2 Married land 21215-0036 1 ☐ Yes 2 🛣 No white Specify. Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Never Worked Never Worked and Mental Hygi Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Howell Yancey Della Huff ဥ Maryl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) p rmit. Pages 1 and 2 s Department of Health ar Ir portant: If Item 27 is any injury or other trau Lucille Chandler/Sister 1492 Dorsey Road Hanover, MD 21076 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sherman Family
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 2-18-2008 Oxford, N.C. 4 Donation 5 ☐ Other (Specify) Sing Leton Funeral and Cremation Services
1 2nd Avenue S.W. Glen Burnie MD 21061 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or coup lications that cause of each. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a a) onsequence of Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy perform 1□ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🔀 No Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural
Accident (Month, Day Year 5 Pending investigation 1 ☐ Yes 2 ☐ No hin 24 hours after death the Funeral Director; 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and addre

State Registrar

31. Date filed (Month, Day,

9

person who completed cause of death (Item 23a) (Type, Print)

08-01333 Robyn Zayon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 04749 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1- For Stare Time of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day February 16, 2008 Physician/ 0045 hrs ZAYON Medical Examiner ROBYN c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Glen Burnie Baltimore Washington Medical Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Foreign Country) **Funeral** Hours Min Months Days 06/27/1983 24 Director M 2XF Yrs 216-13-8535 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a, State 10b. County 1 Yes 2 X No BALTIMORE BALTIMORE is 23a or 28a-f show ie notified at once. or 28a-f show 10g. Citizen of What Country? death with the Maryland Director 10f. Zip Code 10e. Street and Number USA 21208 4 STONE PINE COURT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral White, etc. Armed Forces' 1 X Never Married 2 Married 2 X No Yes WHITE Specify: ō Yes 2 X No specify Divorced If Yes, Give Year Widowed hours after narked other than "natural", event, the Medical Examiner 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done þ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) t. Pages I and 2 should be filed within 72 rement of Health and Mental Hygiene. COSMETOLOGY 21215-0036 BEAUTICIAN 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) VIDA SUSAN ZAYON If item 27 is marked SHELDON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) STONE PINE COURT, BALTIMORE, MD Baltimore, MD SHELDON ZAYON / FATHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State OWINGS MILLS, 02/18/2008 HAR SINAI on tion 5 Other Specify 22. Name and Address of Facility SOL LEVINSON & BROS., INC. ure of Foneral Service Lice 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Physician Death /Medical Narcotic Intoxication Immediate Cause (Final disease kaminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and · transit the Hospital or Attending Physician: The law requires that the death certificate be executed AMENDED 23a Pt. II, 27, 28a-f per ME g877 3/26/08 amh Physician/Medical X UNPENDED attending physician or use as the burial 23d. Date of delivery P.O. Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Month Day 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown signed by the atte 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ۾ Asthma 24b. Were autopsy findings available Completed 24a Was an Division of Vital Records, has been s prior to completion of cause of autopsy death? performed' 2 No 1 🗸 Yes ✓ Yes 2 certificate h 26.Place of Death (Check only one) 25. Was case referred to medical Other, Be Nursing Home 5 Residence 6 Other: examiner? DOA Hospital: 2 V ER/Outpatient 3 Inpatient this 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death Certification: 1 Yes 2 X No Natural Pending Found 11:43pm Jnk<u>nown</u> death. Director: Found 1/15/08 28f. Location (Street and Number or Rural Route Number, City or Jown, State 527 Sylview Drive asadena, MD Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after To the Funeral Dire 6 X Could not be 3 Suicide rasadena, determined (Specify)House 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 16, 2008 O.C.M.E. Muna 30. Name and address of person who completed cause of death (Item 23a) "Blay 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Margarita Korell MD. 31. Date filed (Month, Day, Year)

State Registrar

32 Registrar's Signature

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2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 9:00 P Allen Leroy Ashworth February 6 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours 1**X** M 2□ F Director 215-44-9426 20 1946 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatht and Mental Hygiene. nt: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d Inside City Limits 10a State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 11130 Lakeview Drive Funeral 21740 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3 Widowed 4 Divorced White I Hygiene. other than "natur: rent, the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Painter House Painter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Samuel A. Ashworth Alice Moffet 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cora Ashworth - Wife 11130 Lakeview Drive, Hagerstown, Md. 21740 of Disposition (Name of Date 20c. Location - City or Town, St 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
important; if itel
any injury or oth 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 2/9/08
2 Name and Address of Facility Mins Hagerstown, Maryland 21. Signature of Funeral Service Licenses Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** radu certia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 2 110 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate ha Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner Teath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t 1 - Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated.

WH-4

State Registrar 31. Date filed (Month, Day, Year) FEB 07 2008

even

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number

MDD 66166

400 W.74 St.

Freduck Hem I lloguel

29d. Date signed (Month, Day, Year)

Fiederick Med. 21701

State Registrar

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2008

31. Date filed (Month, Day,

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32. Registrar's Signatu

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	Physicia /Medic	_	CHESTER	DELANE		AMICK		Month 02					
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	Funeral Director		5. Social Security Number 6. Se 217–42–6845	7. Age (In yrs. Id ▼ M 2□ F 64	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Da) 05/23/1	y, Year)	9. Birthi Cou	place (State or Foreign ntry) land		
	PL ,		Usual Residence of Decedent	100 Cit.	, Town or Loc	ation					10d. Inside City Limits		
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	with the N a or 28a-f t be notifie	Direct	10e. Street and Number 12014 Calico			10f. Zip Code	21502		10g. Citizen of	What Cou USA	ntry?		
٥	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natura", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status 1 □ Never Married 2 ◯ Married	12. Was Decedent Ever in U.\$ Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give		Uss Decedent of His Yas Decedent of His Yes, specify Cuban UYes 2⊠No	panic Origin? (Spot, Mexican, Puerto	ecify Yes or No Rican, etc.)	. 14. Ra Bla Speci	ice - Ameri ack, White,			
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Records,	2 50	Completed by	NON REFRACT	HYCARDIA	<del>1</del>			24a. Was autoj	osy	prior to c	topsy findings available ompletion of cause of		
	<b>siclan:</b> The law certificate has b irector, page 2 s	Con						1□ Yes	rmed? 2 No	death? 1 ☐ Yes	2 □ No		
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0	y Physer this eral di	To To	27. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of	I 3 DOA	4   Nursing Ho	me 5 ☐ Resi 28d. Describe			ity)		
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UNISION	l or Atte after dea Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location ( City or To	Street and Nun vn, State)	nber or Ru	ral Route Number,		
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical Co		ysician: To the best of my knowiner: On the basis of examination and manner stated.									
)	To the withing of the transfer	M	29b. Signature and title of certifier  Wulleum	Cann m	D	29c. License	number 5406		29d. Date sign	uaru	1, Day, Year) 1, 4, 2008		
			30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print)	h			7	1 114 1		
	M ★ Sta Registr		31. Date filed (Month, Day, Year) FEB 0 5 201	32 Registrar's Signa	ture	DU Seto	Drive	<u>L'u</u>	mber	<u>land</u>	1, 4, 2008 1, Mary Jund		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 1/30/2008 Norman Lee Andrews 9:55pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 1√2 M 2 ☐ F Days Hours 69 237-66-3181 **Director** April 17,1938 Wilson, N.C. Usual Residence of Decedent 10c. City, Town or Location show 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Maryland| Montgomery Silver Spring 1 TYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8505 Springvale Rd. #215 20901 United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√∑ No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed w h and Mental Hygiel 7 is marked other th Teacher Assistant Education traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Lee Andrews Jessie L. McLaurin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sl
Department of Health an
Important: If Item 27 is r
any injury or other traur Mary A. Andrews / Sister 314 Quarry Ave. Capitol Heights, Md. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Washington National 2/6/2008 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Md. 22. Name and Address of Facility
Alexander S. Pope P. A.
5538 Mariboro Pike/ Forestville, Md. e of Funeral Service Licentee 20747 Part 1. Enter the disease shock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Skin Break Down Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine certificate be executed Failure to Thrive burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Stroke Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death ☐Yes 2☐No P.0. 9□Unknown 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page certificate 1□ Yes 2 **N**0 **Physician:** 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 ☐ No 1 [x]Inpatient 2 ER/Outpatient 3 DOA After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: To the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: A d in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0061887 January 30, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Ira Y. Rabin, M.D.

31. Date filed (Month, Day, Year)

FEB 0 7 2008

32. Registrar's Signature

1500 Forest Glen Rd. Silver Spring, Md.

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Stata Registrar	State of Maryla		artment of rtificate of			giene:	08	04754
	Physic /Medi		1. Decedent's Name (First, Middle, Last	Amar				2. Date of De. Month	Day	Year	3. Time of Death  9:10.A M
	Examination Examin		4a. Facility Name (If not institution, give Bradford Oaks 5. Social Security Number 6. Sec. 177-66-7295	Nursing F	ome last birthday) Yrs.	4b. City, Town,  If Under 1 Year  Months Days		ath  S. 8. Date of Birt	4c Count	y of Death Ce G	leorges ace (State or Foreign arolina
	Maryland -f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  MD Prince (	Georges 10c. c	ity, Town or Lo	lover			/	10	od. Inside City Limits
	th with the 23a or 28e ist be noti	Funeral Director	10e. Street and Number 2416 Virginia A			10f. Zip Code	0785		10g. Citizen of	What Count	try?
980	be filed within 72 hours efter death with the Maryland tal Hyglene. Id other than "natural", or Items 23a or 28e-f ehow event. I're Medical Examinar must be notified at	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cut 1 ☐ Yes 2D No		Specify Yes or No rto Rican, etc.)	14. Ra Bla Specia	ce - America ck, White, e	
21215-0036		Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire Engine	during most of word)	orking	16b. Kind of B		ustry
Maryland	should be filed and Mental Hygle s marked other umatic event.	To Be (	17. Father's Name (First, Middle, Last) Herman Am				Dore	ame (First, Middle, 2 Hha /	1c Bri	de	
	s 1 and 2 should if Health and Mer item 27 Is marks other treumatic		Betty Amos (	Wife)	24/	dover	Inia A	Ryral Route Number	207	85	
Baltimore,	Pages nent of ant: If it		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	cemetery, crer SULTYEC	sition (Name of natory or other pla Fron Cen	1. Feb	7, 2008	Clini	on 1	1
Bal	permit. Departr Importe any inju		21. Signature of Funeral Service License (ulph 2.)	Vellama	10	13 101011	iac Ave		113011110 1	in D	c 20103
	Frrysician /Medical Examiner		23a. Pàrt1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	ications that caused the dea ne cause on each line.	quence of):	er the mode of dy  As w/s  Li &	ng, such as cardi	ac or respiratory ar	rest,		Approximate Interval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	dicai Examiner	any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last		quence of):					/	/
P.O. Box 687	the death certify the attending ched for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of 6	aldeath 3□	Ectopic pregnanc Other (specify)	у			ite of deliver	y Day Year
_	quires that n signed by ald be deta	þ	Part II. Other significant conditions con	ntributing to death but not res	sulting in the ur	nderlying cause gr	ven in Part I.		obacco use con	tribute to the	e cause of death?
	iclen: The law requires certificate has been sign ector, page 2 should be	Completed						24a. Was autop perfor 1 \( \text{Yes} \)	med?	Were autop prior to con death? 1 \( \text{Yes} \)	sy findings available apletion of cause of
	ing Phys After this uneral dir	ation; To Be	25. Was case referred to medical examiner?  1 Yes 2 H  27. Manner of Death  1 Natural 5 Pending investigation	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpation 28b. Time of Injury	28c. Inju	ner: 4 virsing	eath Check onl of Home 5 Resid	ence 6 🗆 Oth		
É	el or Attend s after death il Director: /	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, stre (y)	eet, factory, office		28f. Location (S City or Tow	itreet and Numl n, State)	ber or Rural	Route Number,
	To the Hospitel within 24 hours a To the Funeral Completely filled	edical C	29a. Certifier Certifying Physical Control (Check only one)	sician: To the best of my knowner: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the trestigation, in my	me, date and plac opinion, death occ	e, and due to the curred at the time, o	ause(s) and malate and place,	anner as sta and due to	ited. the cause(s)
	To the comp	Me	29b. Signature and title of safelier			29c Licen:	943)		29d. Date signe	d (Manth, E	ay, Year)
R	[3]		30. Name and address of purson who could be seen and address of purson who could be se	mpleted cause of death (Iter	2014	Print)	(A #	103 77	491	my	W 162079
	Sta Registr	20	FEB 0 4 2008	See Level A	books						1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Dep 1- State State Registrar Amend 25&27, perME,g877 3/4/08 TT Ce				iene eg. No. 20	08 04755
F	-11		1. Decedent's Name (First, Middle, Last)		Douil,	2. Date of Deat	th	3. Time of Death
	Physici /Medic		John Lattery Addison Sr.			January 2	28, <sup>Day</sup> 2008	6:19 A M
)	Examin	er	4a. Facility Name (If not institution, give street and number)		or Location of Death		4c. County o	
			Southern Maryland Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Clinton  If Under 1 Year	If Under 24 Hrs.	8 Date of Birth		George's  9. Birthplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 20 F 75 Yrs.	Months Days	Hours Min,	8. Date of Birth (Month, Day, March 11,	Year) 1932	Country) Virginia
	pu »		Usual Residence of Decedent	acation				
	faryla shov ed at	ō						10d. Inside City Limits 1 ☐ Yes 2 1 No
	the N 28a- notifi	rect	Maryland Prince George's Ft. Wash:	10f. Zip Code		1	0g. Citizen of W	hat Country?
	th with 23a or ist be	al Di	2210 Peirmont Drive	20744			USA	
	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral Directo	I Armed Forces?	. Was Decedent of H	Hispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, , White, etc.
20	s afte ", or il	by Fi	1 □ Never Married 2 ★ Married 1 ★ Yes 2 □ No 1952 → If Yes, Give 1961	1 ☐ Yes 2ĀĀNo	Specify:	,		Black
2-0030	2 hour atural cal Es		15. Decedent's Education 16a. Dec	edent's Usual Occup	pation	-7	16b. Kind of Bus	siness/Industry
7	thin 7 le. an "n Medi	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  Oth  (Giv life.  Heati	e kind of work done DO NOT use retired ing & Air Co	during most of work d) and it i on in a	ing	Fodorol C	overnment
7	led wi lygien her th nt, the	S		ig & Air W				
a 2 2	d be fi	Be c	17. Father's Name (First, Middle, Last) UNKNOWN		18. Mother's Name	e (First, Middle, I Addison	Maiden Surname	9)
Ž	should nd Me mark imatic	은		ling Address (Street	L.,		. City or Town, S	State, Zip Code)
M.	and 2 alth a 1 27 is er trau	li į	Shirley Addison / Wife 2210	Peirmont Dr	ive Ft. Wasl	nington, M	Maryland	20744
9	of He		20a. Method of Disposition  20b. Place of Disposition  20b. Place of Disposition  20cemetery, critical 2 □ Cremation 3 □ Removal from State	oosition (Name of ematory or other pla	ce)	Date	20c. Location - 0	City or Town, State
Dairimo	: Pag tment tant; I		4 □ Donation 5 □ Other (Specify)   Mary Land	Vet. Cemete				m, Maryland
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			22. Name and Addre		_		al Home PA
ħ.			23a. Part Enter the disease, or complications that caused the death. Do not enshow or heart failure. List only one cause on each line.	6160 Oxon H				Approximate
	Physician	Y 1	Immediate Cause (Final					Interval Between Onset and Death
+	/Medical		resulting in death)  a.  Due to (or a a consequence of):	dants	•			In in nout
	Examiner	<u></u>	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of	Tonly	,			Certhown
	nsit	nine	Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	70	atrona	./		wlenos
,	execu in and ial-tra	Examiner	resulting in death) Last  c. Due to (or as a consequence of):	and	81 com	1		minosy
0/00,	ficate be executed physician and s the burial-transit	dical	d	Iroda 1	DNGS	97		
ŏ X	ertifica ding pl	/Med	IF FEMALE:	A CHI	A HOOS			
0	attend for us	cian,	If the past 12 months?	☐Ectopic pregnancy	у		23d. Date Mon	e of delivery th Day Year
į	t the d by the ached	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown					
ב, מ	siclan: The law requires that the death certificate has been signed by the attending prector, page 2 should be detached for use as	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause giv	ven in Part I.	23e. Did tob	oacco use contri	bute to the cause of death?
5	requir een si nould l		2e not w			1 □ Y€	es 2 No	3 Probably 4 Upknown
ה ה	e law has b	Completed				24a. Was a autops perforr	sy l	Vere autopsy findings available rior to completion of cause of eath?
<u></u>	n: Th fficate or, pag	e Co	25. Was case referred to medical		00 Pl (D (	1□ Yes 2	2 1 No 1	Yes 2 No
>	Physician: r this certifica ral director, I	0 B	examiner?  1 X es 2 ER/Outpatie  Hospital: 1 Inpatient 2 ER/Outpatie	ent 3 DOA Oth	26. Place of Death ner: 4 ☐ Nursing Ho	me 5 ☐ Reside		r (Specify)
5	ding Phystclan: The n. After this certificate he funeral director, page	T:UC	27. Manne of Death  15 Natural 5 Pending (Month, Day Year) 28b. Time (Month, Day Year)	of 28c. Injur		28d. Describe ho	ow injury occurre	of C-tube
2	ttendi	cati	2 Accident investigation 3 Accident 3 Suicide 6 Could not be		Yes 2. No			aced from
5	aler d aler d Direc	Certification:	4 ☐ Homicide determined building, etc. (Specify)	one		City or Town	n, State) A (1)	or Rural Route Number,
	To the Hospital or Attending within 24 hours at er dea.h. To the Funeral Director: Aftel completely filled in by the fune		29a. Certifier (Check only (2 Medicar Examiner: On the basis of examination and/or i	ath occurred at the tir	me, date and place,	and due to the ca	ause(s) and mar	nner as stated.
	the H hin 24 the F mplete	Medical	one) and manner stated.				, .	
	To cor	Σ	29b. Signature and the of certifier Arastoo Yazdani MD	29c. Licens	C C C	_	_	(Month, Day, Year)
)	14/1	Ì	30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	73/	-	JUI NUX	7,28/08
	UTI		9400 LIVINGSTONRE 3-350 F	= worthers)	Lylan	0207	44	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 0 4 2008					
	Registra	al I	LEDAZ TO THE LOCAL DESIGNATION OF THE PERSON					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of N	/laryland / D	epartmer Certificat			nd Mer		iene eg. No.	008	04756
				e (First, Middle, La	st)					2.	Date of Deat			3. Time of Death
	Physic		DIANNE	EX	та г	AGRAMONT	TE:			ਜ	Month EBRUA	Day PV 8	3 2008	10:35 <sup>P</sup>
	/Medi Exami				e street and numbe			Town, or t	ocation of		<u> </u>		ounty of Death	
			20 KING	с ынхог	DIACE		7.7.7	TDOE	n Er			C	HARLES	
	Funeral	- 2.5	38 KING 5. Social Security N			Age (In yrs. last birt	hday) If Unde Months	Days	If Under 2		Date of Birth (Month, Day,		9. Birthr	place (State or Foreign
	Director		213-42-	9639	□M 2KINE	65	rs.	Days	Hours				42 OHI	* '
	pur *		Usual Residence of 10a, State	Decedent 10b. County		10c. City, Town	or Location							10d, Inside City Limits
	laryk •ho	ō			C	, ,								1 ☐ Yes 2 ☑ No
	28a-f	Director	MD 10e, Street and Nu	CHARLE	<u> </u>	WALDO	10f. Zij	Codo			1	Oo Citizo	n of What Cou	
	death with the Maryland ms 23a or 28a-f ehow r must be codified at	Ö			DIAGE				,		'			
	ns 23	era	11. Marital Status	S WHARF	PLACE 12. Was Deceder	nt Ever in U.S.	13. Was Dece	20602 dent of His		in? (Specify	Yes or No-		. S. A	
10	r Iten	Funerai		ied 2 Married	Armed Forces	5?	If Yes, spe	cify Cuban	, Mexican,	Puerto Ric	an, etc.)		Black, White,	
036	hours after tural', or ite al Evantre	by	3 Widowed		1 □Yes 2 Notes of the Part of Dates	₹	1 🗆 Yes	2 <b>XIX</b> 10	Specify:			S	рес <i>ify:</i> WHI	TE
21215-0036	2 should be filed within 72 hours and Mental Hygiene. Is marked other than "natural", aumatic event, the Medical Eva	Completed	/Saar	15. Decedent's Ed	ducation	16a.	Decedent's Usu (Give kind of wo	al Occupat	ion	of working	1	16b. Kind	of Business/In	
21	within 7 ene. than "r	pie	Elementary/Seco	<del></del>	College (1-4o	r 5+)	life. DO NOT u	se retired)	mng most c	or working				
	ed wi	Con	11			DAY	CARE	PROV	/IDER	2	3	ELF.	-EMPLC	YED
nd	be filk tal Hy d oth	Be (	17. Father's Name	(First, Middle, Last)				1	18. Mother	's Name <i>(F</i>	irst, Middle, I	Maiden Su	ımame)	
Maryland	ould Men arke	P			S MCCULI	LOUGH			EXI	IA DR	UMMON	1D		
lar	2 sh and le m			ame/Relationship (			Mailing Address							
	l and fealth im 27			ODWIN/D	AUGHTER		KINGS  Disposition (Nat		ARF F	PL. W				
0	iges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f ehow or other traumatic event, the Medical Examinar must be notified at		20a. Method of Disposition 1 Burial 2	•	Removal from Stat	e cemeter	r, crematory or c	other place,	l L	EBRU	ARY		tion - City or To	
tim	Part and			5 Other (Specif		METRO	POLITA		₹.   1	13,20	08 A	LEX	ANDRIA	, VA
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr.		21. Signature of Fu	ineral Service Licer	at 8	to	22. Name ar	nd Address VASH1	of Facility	RAYM N AV	OND F	UNL LA P	. SERV LATA,	ICE,P.A. MD 20646
			23a. Part1. Enter to shock, or hea	he disease, or com rt failure. List only	plications that caus one cause on each	ed the death. Do n line.	ot enter the mod	te of dying,	such as c	ardiac or re	spiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause disease or condition	(Final	1-V	NE	Cay	CP					1	Onset and Death
	/Medical		resulting in death)		м	s a consequence o		( 6						
	Examiner		Sequentially list co	nditions	b. ————									
V	D ==	ner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or	nmediate erlying	Due to (or a	s a consequence o	f):							
	xecute and Il-trans	Examiner	Cause (Disease or that initiated events resulting in death) I	i	c									
30,	sate be executed oblysician and the burial-transit	Û	rosulting in dodiny		Due to (or a	s a consequence o	r):							
8760,	ate be ex physician the buria	dicai		•	d									
9	fing p	Me	IF FEMALE:	-	00- 14									
Вох	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as:	Physician/Me	23b. Was deceden in the past 12			2 Fetal death	3 □Ectopic p					230	<ul> <li>Date of deliv</li> <li>Month</li> </ul>	ery Day Year
	the de	ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown		9□ Unknown	at time of death	5 Other (sp	овспу)						
P.0	that the de ed by the detached	P	Part II. Other signif		ontributing to death	but not resulting in	the underlying o	ause diver	in Part I.		23e. Did tob	pacco use	contribute to t	he cause of death?
ds,	uires that signed b d be det	d by			<b>3</b>	<b>-</b>		g				s 2 🗆 l		
Records,	w requir been si should	Completed						-			<del></del>			
žě	The law	mpi									24a. Was a autops perforn	v	prior to co death?	opsy findings available impletion of cause of
a											1 ☐ Yes 2	- TONO	1 🗆 Yes	2 □ No
Vital		Be	25. Was case refer examiner?	0	Hospital:	-57					heck only on			-
of		T.	1 ☐ Yes 2 ☐ 27. Manger of Deat	-	1 L Inpa			28c. Injury a			. Describe ho		Other (Special	fy)
O	ding I h. After funer	tion	Natural 2 Accident	5 Pending investigation	28a. Date of In (Month, D	ay Year) In	jury	Work?	n" es 2.⊟No			,, .	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Division	Attendi death. ctor: A	fica	3 Suicide	6 Could not be	28e. Place of I	njury - At home, far	m, street, factor						Number or Run	al Route Number,
<u>D</u>	after after Dire	Certification;	4  Homicide	determined	building,	etc. (Specify)		,,			City or Towr	n, State)		
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier	1₽ Certifying Ph	ysician: To the bes	t of my knowledge,	death occurred	at the time	, date and	place, and	due to the ca	ause(s) ar	nd manner as s	stated.
	ne Ho	Medicai	(Check only one)	2 ☐ Medical Exan	niner: On the basis and manner:	of examination and	or investigation	, in my opir	nion, death	occurred a	at the time, da	ate and pl	ace, and due t	o the cause(s)
	Within To the Comp	Σ	29b. Signature and	title of certifier	\		290	. License	number		2:	9d. Date	signed (Month,	Day, Year)
			1 St	MI	h-			02	831	1 2		21	11/0	5
	2		30. Name and addr	ess of person who	completed cause of	death (Item 23a) (	Type, Print)	1	11		100	^	000	26
			P	0	18-X	17	05	CF	(ef.	2 1		0	106	46
	Sta		31. Date filed (Mon.			trar's Signature		o .						
10	Registr	ar		FEB 16	2008	GUES AS	STATE OF	and the same of th						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Month **Physician**  $A^{M}$ 5, 6:50 LOIS HARMON BOATWRIGHT February 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Citizens Care & Rehabilitation Ctr. Frederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, March 17 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🙀 F 220-12-7508 96 1911 Virginia Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f sh notified 1 ☐ Yes 2 ☐ No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ral", or items 23a or Examiner must be r 1900 Rosemont Avenue 21702 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: 3X Widowed 4 □ Divorced White Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 'Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Rush Harmon Ada Paxton 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Christine Harmon / Niece 11215 Angleberger Road, Thurmont, MD 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/6/08 4 □ Donation 5 □ Other (Specify) Smithsburg Crematory Smithsburg, Maryland 21. Signature ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET STREET, FREDERICK, MD 21701 23a. Part1. Enter the directle, or commendations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirtle, if leart failure. List only one cause on each line. Approximate Interval Between Onset and Death CarlioVasidor Immediate Cause (Final disease or condition resulting in death) **Physician** serten /Medical or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unkny Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes No. 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? cate has I autopsy performe certificate 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 1 Tyes Nursing Home 5 Residence 6 Other (Specify) ٩ 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director; 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and the of confifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who complete of death (Item 23a) (Type, Print) 300 West 9th Street, Frederick, Maryland 21701 Robert L. Kaufmann, MD 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Certificate of Death

10:13 a™

10d. Inside City Limits

1 X Yes 2 No

MNUTES

MONTERS

Year

Maryland

white

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 6, 200<sup>real</sup> Donald Lee Baker /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington 323 W. Howard Street Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 214-34-2363 70 April 19,1937 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural" or Items 23s are not any injury or other traumatic access. 10c. City, Town or Location 10a. State 10b. County Director Maryland Hagerstown Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21740 323 W. Howard Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □Xres 2 □ No If Yes, Give 1962-68 Year or Dates:1962-68 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: ģ 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) various companies 11truck driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thurman Charles Baker Helen Hessong Baker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 607 Shasta Court, Highland Village, TX 75077 Heath Baker - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State 2/9/08 Cedar Lawn Mem. Park Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licen MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Physician/Medical the as attending for use IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by MELLITHS ES 1 Yes 2□ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No has N page ; 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 2 27. Manne of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) injury 1 Naturai 5 Pending investigation 1 ∏Yes 2 ∏No 2 Accident 24 hours after death Puneral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Piace of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertifier 29c. License number February

DHMH 17 Rev 1/2001

State

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) //// []

BeckwITH

FEB 0 7 2008

31. Date filed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	amin		4a. Facility Name (If not institution	n, give street and nu	ımber)		4b. City	, Town, o	r Location of Death		4c. Count	ty of Death	
			HOLY CROSS HOS	PITAL			SILV	ER S	PRING		MONTG	OMERY	
Fune	eral		5. Social Security Number	6. Sex <b>X</b> XM 2 ☐ F		yrs. last birthda	/) If Unde		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	y Year)	9. Birthp	place (State or Foreign
Direc	tor		579-36-3435	1121VI 20 F	73	Yrs.				2-10-19			ington DC
and w			Usual Residence of Decedent  10a. State 10b. County		10	c. City, Town or	Location					1.	10d. Inside City Limits
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ed wi	r, me	ပ္ပ	12			Spec	lal Po	lice	Officer		Gover		
be fill H doth	ua a	Be	17. Father's Name (First, Middle, James Blackburn	,					18. Mother's Nam	, , ,	Maiden Surna	ıme)	
s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  Item 27 is marked other than "natural", or items 23a or 28a-f show than the recomposition in the fired of the fired in the	anc	၉			-				Rosie Yo				
2 6 6 5 6	raun	- 2	19a. Informant's Name/Relations			19b. Ma	iling Addres	s (Street	and Number or Ru. #531A	ral Route Numbe	r, City or Towi		
1 and 2 Health a tem 27 is			Roy Blackburn  20a. Method of Disposition	Jr.	Ta	8/50 Ob. Place of Dis			Ave Silve	er Sprin	-	209	
iges If ite	5		1 Burial 2 ☐ Cremation	3 ☐Removal from	State	cemetery, co Lincoln	ematory or Ceme t	other plac Cerv	2-6-2		20c. Location Suitla:	•	own, State
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Physici	ian	7	Immediate Cause (Final disease or condition	•		PARKINS	LU NU	CEVC	ជ			-1	Onset and Death
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The law requires that the death certificate be executed at has been signed by the attending physician and hans 2 should he detached for use as the burial-transit		dical		d	310 (	JICHNINI							
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g Ph g	g	-1	27. Manner of Death	28a. Date		28b. Time	of	28c. Injur Worl	v at	28d. Describe h			<i>y</i> /
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Atte	, h	iji	3 ☐ Suicide 6 ☐ Could determ	.:   Zoe. Place	e of injury - ling, etc. (S	At home, farm,	treet, facto	ry, office		28f. Location (S City or Tow	treet and Num	ber or Rum	al Route Number,
a after series of series o		Certification:								Only of you	ii, otato)		(
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral incorpt in complete the complete of the properties of the complete of the properties of the complete	oleiy III	edical	29a. Certifier (Check only one)   * ☐ Certifyir 2 ☐ Medical	ng Physician: To the Examiner: On the b	e best of my basis of exa oner stated.	y knowledge, de amination and/or	ath occurre investigatio	d at the tir	me, date and place opinion, death occu	, and due to the or rred at the time, or	cause(s) and n	nanner as s , and due t	stated. to the cause(s)
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State Registrar 31. Date filed (Month, Day, Year) FFB 0 5 2008

30. Name and add of person wh



pleted cause of death (Item 23a) (Type, Print) 3001 HOS Detail DVIVE Cheverly MD 20785

			For State Registrar	State of Mary	_	artment of H r <i>tificate of I</i>			giene, Reg. No.	Z 1 1 1 1 1 3 5	04761
r			Decedent's Name (First, Middle, Last)					2. Date of Dea		Voor	3. Time of Death
£,	Physicia /Medic		James Clayton Blo	od				Februa:	ry 2.	, 2008	6:20 P M
	Examin	2 24	4a. Facility Name (If not institution, give str	eet and number)			Location of Death			County of Death	
eg tát s		H <sup>E</sup>	Dove House	1		Westminst	ter If Under 24 Hrs.	8. Date of Birt		rroll	alana (Ctata ar Faraiga
Š	Funeral Director		5. Social Security Number 6. Sex 1払 N	7. Age (In	yrs. last birthday) 71 Yrs.	Months Days	Hours Min.	June 3	V. Year)	936 Ohio	place (State or Foreign ntry) 
	w w		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Lo	ecation				· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits
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	the 7	Director	MD Frederick  10e. Street and Number		COCKY KIC	10f. Zip Code			10g. Citiz	en of What Cou	ntry?
	n with	Ē	9209 Appolds Road			21778			USA		
	death	Funeral		. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	- 1	4. Race - Ameri	
98	should be filed within 72 hours after death with the Maryland and Mental Hygiene. I warked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at		1 Never Married 2 Married	1 X Yes 2 □ No If Yes, Give		1 ☐ Yes 2 🔯 No	Specify:			Specify: Whit	- 0
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Maryland 21215-0036	e file al Hy d othe	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden S	Surname)	(unk)
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Mar	12sh hand 7Ism traum		19a. Informant's Name/Relationship (Type	. Print)		ng Address (Street					p Code)
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nog	ages ent of tr: If it		1 ☐ Burial 2 【Cremation 3 ☐ Ref 4 ☐ Donation 5 ☐ Other (Specify)	noval from State		matorý or other plac ke Cremat		)5/08	Belt	sville,	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee			2. Name and Addre			ce	P.O. Bo	x 784
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ŧ.			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	ations that caused the cause on each line.	death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
W.	Physician		Immediate Cause (Final disease or condition	Respirate	ry Failu	re					
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		-G	Sequentially list conditions, b.	Aspiration Due to lor as a co	n Preumoi	nia					
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ion	Attending r death. ector: After oy the fune	atio	1 Natural 5 Pending 2 Accident investigation	(World), Day 10	Sal/ Injury		Yes 2 □ No				
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	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	Mec	29b. Signature and title of certifier			29c. Licens	se number		29d. Dat	te signed (Monti	n, Day, Year)
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61	1)00		30. Name and address of person who cor Magan Pansuriya, M	npleted cause of death	h (Item 23a) (Type	, Print) • Westmin	nster, MD	21157			
	Sta	ate	31 Date filed (Month, Day, Year)		Signature						
	Regist	rar	FED U 5 20	08 Rosers	J. D. K	perce					

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

Directo

Funeral

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Completed

Be

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**Funeral** 

**Director** 

or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death be Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a any injury or other traumatic event, the Medical Examiner must

Baltimore, Maryland 21215-0036

Exam Physician/Medical Completed

burial-transit and attending physician as the nse for signed by the at Id be detached fo ector,

death certificate be executed

Division or Vital Records, P.O. Box 68760,

funeral filled in by the

Be

<sup>2</sup>

Certification:

Medical

To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely oth State Registrar

Attending Physician;

Other: 4 Nursing Home 5 Residence 6 Mother (Specify) hospice 1 ☐ Yes 2₹ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapnerstated. (Check o one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

D64615

February 1, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Genevieve Wroblewski, M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855

31. Date filed (Month, Day, Year) FEB 05 2008

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Mary		artment of H			21111	8 04763
		Registrar  1. Decedent's Name (First, Middle, Last)	Cer	lilicate of L	Jeani	2. Date of Dea	1eg. No.	3. Time of Death
Physici						Month	Day Yea	ar a M
/Medio Examir		Floyd Murray B 4a. Facility Name (If not institution, give street and number)	oring	4b. City, Town, or	Location of Death	Februa	ry 1 2000 4c. County of Do	3 7:30 gath
Apple to the second second second		15101 Interlachen Drive, #1	17	Silve	r Spring If Under 24 Hrs.		Mont	gomery
Funeral			n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day June 25	h g r	Birthplace (State or Foreign Country)
Director		Usual Residence of Decedent	92 Yrs.			June 25	, 1915	New York
yland iow at			c. City, Town or Lo	cation				10d. Inside City Limits
a-f sh ified	ctor	Maryland Montgomery		Silver S	nrina			1 □ Yes 2 No
or 28	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?
ING Z I Z I 3-UU36 be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notitied at	ral	15101 Interlachen Drive, #1			0906	7 1	USA	marinen Indian
ter de items ner n	Funeral	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married	r in U.S. 13. V	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	Rican, etc.)	Black, W	merican Indian, hite, etc.
VITI 13-UU36 within 72 hours after ene. than "natural", or ite the Medical Examine	by	If Vos Chro	WWII era	1 ☐ Yes 2 ☒ No	Specify:		Specify:	White
72 hou	ted	15. Decedent's Education (Specify only highest grade completed)		dent's Usual Occupa		dna	16b. Kind of Busine	ss/Industry
ithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	OO NOT use retired	)		U.S. Depar	rtment of
al Hygier other tr		47. Falbada Nassa (Cima Middle Land)	Se	cret Serv			Treasury	
and d be fill ental H ced oth c even	Be	17. Father's Name (First, Middle, Last)					Maiden Surname)	
riaryianc	2	Earl Cleveland Boring  19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ng Address (Street a		rances		e, Zip Code) 20906
Malanda sulth ar sult		Judith A. Orzell/Daughter						ver Spring, MD
Demit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked, any injury or other traumatic evonce.	. 3	20a. Method of Disposition	20b. Place of Dispo			Date 8,	20c. Location - City	
allino rmit. Pages partment of portant: If I y injury or ce.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) entombment	-		· 1		Silver Spi	ring, Maryland
rmit.		21. Signature of Funeral Service Licensee	22	. Name and Addres	ss of Facility		Home Inc.	
	1. 1	Aque & Dos		<u>00 Univers</u>	sity Blvo	l, W, Si	lver Sprin	ng. MD 20901
		23a. Part1. Anter the disease, or complications that saused the shock, or heart failure. List only one cause on each line.	death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory as	rrest,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)  a. Congest	ive Heart	Failure				2 Weeks
/Medical Examiner		Due to (or as a co	onsequence of):					
	-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a condition)	onsequence of):					1
uted d ansit	Examine	Cause (Disease or injury that initiated events						
exec an and rial-tra	Exa	resulting in death) Last  Due to (or as a co	onsequence of):					
oertificate be executed dring physician and use as the burial-transit	dical	d						
entifica ing pt	Med	IF FEMALE:						
death cer e attendin	hysician/Me	23b. Was decedent pregnant in the past 12 months?	Fetal death 3	Ectopic pregnancy	,		23d. Date of Month	delivery Day Year
he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	ie of death 5∟	Other (specify)				
w requires that the death certific been signed by the attending p should be detached for use as	0	Part II. Other significant conditions contributing to death but n	ot resulting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use contribute	e to the cause of death?
w requires been sign	d by	Renal Failure, Hypertension				1 🗆 🕆	Yes 2∏xNo 3∏	Probably 4 Unknown
law rec	Completed					24a. Was		autopsy findings available
The lay te has age 2	J Wo					autor perfo 1⊟ Yes	rmed? death	to completion of cause of n? ∕es 2  No
lan: lan: rtiffica	Be C	25. Was case referred to medical examiner?			26. Place of Dea			00 20,10
hysic his ce I direc	ToE	1 ☐ Yes 2√☐ No Hospital: 1 ☐ Inpatient	2 ER/Outpatien		4 Li Nursing H	ome 5 Resid	dence 6 Other (S	Specify)
ing Ph		27. Manner of Death 1 Natural 5 Pending  28a. Date of Injury (Month, Day Y	ear) 28b. Time of Injury	Worl		28d. Describe I	now injury occurred	
Attending or death.  Tector: After by the functions	cati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury.	At home farm etr		Yes 2 □ No	28f Logotion /	Strant and Number or	Dural Doute Number
Jor A affer of Direct lin by	Certification:	4 Homicide determined building, etc. (	Specify)	eet, factory, office		City or Tov		Rural Route Number,
spital nours neral / filled		29a. Certifier XX Certifying Physician: To the best of n	ny knowledge, death	h occurred at the tin	ne, date and place	, and due to the	cause(s) and manne	r as stated.
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical	(Check only one)  2 Medical Examiner: On the basis of example and manner stated	amination and/or in I.	vestigation, in my o	pinion, death occu	rred at the time,	date and place, and	due to the cause(s)
Withi To the	Ž	29b. Signature and title of certifier		29c. License			29d. Date signed (M	
15+1		Novem r. Tress	M4)	D347	40		February 1	2008
13		30. Name and address of person who completed cause of deat		•	0.1	WD 0000	•	
0.		Of Data filed (March Day, Year) 20 Aprintendo	ince Phil		Olney,	MD 2083	<u>Z</u>	
Sta Registi		FEB 0 4 2008	J. J. Ago	action				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Elizabeth Blasic 2 9 50A 01 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

55 . Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗙 1<sup>M</sup>2<sup>2</sup>9<sup>3</sup>42<sup>2</sup>668 Maryland none Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at MD Montgomery Gaithersburg 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Maryland Avenue 20877 USA Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
Instit If lean 27 is marked other than "natural", or items 23st mirt. If lean 27 is marked other than "natural", or other traumatic event, the Medical Examiner must viny or other traumatic event, the Medical Examiner must Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: El Salvador 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Blasic Claudia Figueroa ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Blasic/Father 9 Maryland Avenue Gaithersburg, Md. 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of I Important: If Its any Injury or o once, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crem. 2/02/2008 Beltsville, Md. 4 □ Donation 5 ☐ Other (Specify) weral Service Licen 21. Signature of 50 PHILTP AT THALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician Physician/Medical the use as f IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes Were autopsy findings available prior to completion of cause of 24a. Was an ate has page 2 s autopsy performe death? 1 ☐ Yes 2 ☐ No sertificate 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Certification: To Be Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this funeral ( 27. Manner of Death 28a Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation (Month, Day 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: ours after death.

neral Director: A
filled in by the fu within 24 hours a

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) XX 2667C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHNSON FAN, SHADY GROVE ADVENTIST, 9901 MEDICAL CENTER DRIVE, ROCKVILLE MD 20850

State Registrar

Medical

29a. Certifier

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 2, Day 2008 Year Albert L. Baumgartner 9:00 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2103 Belfast Drive Prince George's Ft. Washington 8. Date of Birth (Month Pay, Year) Aug. 17, 1913 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 577–10–3257 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Pennsylvania 6. Sex **Funeral** Days Hours 1**X** M 2 □ F Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 ☐ Yes 🙀 No Prince George's Ft. Washington Marvland 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? "natural", or Items 23a or 3 edical Examiner must be n 20744 USA 2103 Belfast Drive death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. filed within 72 hours after 1 Yes XX No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2 No Specify: White 2 Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 is marked other than ury or other traumatic event, the M College (1-4or 5+) Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Catherine Loeb Albert. Baumgartner ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary T. Baumgartner / Wife 2103 Belfast Drive Ft. Washington, Maryland permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr Method of Disposition

T

Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Resurrection Cemetery :02/07/2008 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA of Funeral/Service Licensee 1.16h 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner requires that the death certificate be executed use as the burial-tran resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No be detached 9☐Unknown 9 ☐ Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2No 3☐ Probably 4☐Unknown Completed The law 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an has page 2 autopsy certificate 1∐ Yes 24X No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) 2 No 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA this after death.
I Director: After this
id in by the funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 KN Natural 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, 2008 FEB 04

\$ignature and title

30. Name and address of

SAN 32. Registra

se of death (Item

manner stated.

on who completed o

23a) (Type, Print) 5100

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1 - State Registramend#19a.PerFHI	PGC2-6-08ar		artment o			g. No. 4 UUO	04766
· ·	Physic /Medi		1. Decedent's Name (First, Middle, Last)  Justine I					2. Date of Death Month 1/3	Day Year 0/2008	3. Time of Death 8:50 a.m
di A	Exami	ner	4a. Facility Name (If not institution, give s	street and number)		4b. City, Town	n, or Locetion of	Death	4c. County of Death	
			8202 15th Avenue	1 = 4 0			ttsville		Prince Ge	
	Funeral Director		5/8-/2-6635	7. Age (In	yrs. last birthday) 88 Yrs.	If Under 1 Ye Months Da		Min. 8. Date of Birth (Month, Day, 10/25/1		place (State or Foreign intry) aine
	land		Usual Residence of Decedent  10a. State 10b. County	10c	. City, Town or Lo	cation				10d. Inside City Limits
	Mary	ŏ	MD Prince Ge	orge's	[yattsvi]	110				1 ☐ Yes 2 ☑ No
	r 28a	irec	10e. Street and Number	20166 3	iyaccsvii	10f. Zip Cod	le	10	g. Citizen of What Cou	intry?
	th with	Funeral Director	8202 15th Avenue			2078	33		U.S.A.	
	r dea	ner	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of	of Hispanic Origin	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Amer Black, White	
36	or it	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 📉 No If Yes, Give		1 ☐ Yes 2 🖾 i		dono modn, etc./	Specific	
Ö	72 hours after death with the Maryland naturel', or iteme 23a or 28a-f show alical Evaridi.wir must be notified at	d by	3⊠ Widowed 4 □ Divorced	Year or Dates:	1 10 0				Wn	ite
5	in 72 in mai	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced	dent's Usual Oct kind of work do: DO NOT use ret	cupation ne during most o tired)	of working	6b. Kind of Business/Ir	ndustry
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Maryland 21215-0036	e filec Il Hyg othe	BeC	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle, Ma	uiden Sumame)	
lar	uld by Aenta rked tic a	ToE	Iwan Korotynska				Ann	a Schkolnik		
ar)	2 sho and ? is ma		19a. Informant's Name/Relationship (Type Davisor		19b. Mailir	ng Address (Stre	eet and Number	or Rural Route Number, (	City or Town, State, Zi	c Code)
≥,	and ealth m 27		Vera Marie <del>Davidse</del>	<del>n</del> , Daughter				ve., College	e Park, MD	20740
ore	Jes 1		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re		<ul> <li>b. Place of Dispo cemetery, cren</li> </ul>	sition (Name of natory or other p	olace)	Date 20	c. Location - City or T	own, State
ij	tant:		4 Donation 5 Other (Specify)		Cedar Hi	L1 Cemet	tery 2	/4/2008 S	uitland, M	D
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or itame 23s or 28s-f show any injury or other traumatic avent, the Medical Evantimat must be notified at ance.		21. Signature of Funeral Service License	ee L			dress of Facility			imore Ave.
	40244	$\square$	23a. Part1. Enter the disease, or complied	c Nasak				Home, P.A.	Hyattsvil	le, MD 2078
F	Pnysician /Medical		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	+ +10	None	- Ju	han be	1,	Approximate Interval Between Onset and Death
8760,	death certificate be executed XXIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying tase (Lie and or inst) that initiated events resulting in death) Last	Due to (or as a con						
P.O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3	Ectopic pregnal Other (specify)			23d. Date of deliv Month	ery Day Year
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Division of Vital Records,	The lar	Completed						24a. Was an autopsy performe	prior to co	opsy findings available impletion of cause of
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of	E 5 = 1	. To	1 Yes 2 No	ospital: 1 Inpatient 2		3 DDA	other: 4 ☐ Nursi	ng Home 5 Residence		(y)
0	ding h. After fune	ig	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury		Vork?	28d. Describe how	injury occurred	
Jivisi	of or Attending Physicien: after death. Director: After this certification by the funeral director.	ertification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, streecify)		☐ Yes 2 ☐ No ee		et and Number or Run State)	al Route Number,
	To the Hospitel within 24 hours a To the Funeral completely filled	edical C	29a. Certifier (Check only one) 12 Certifying Physical Examin	icin: To the best of my left On the basis of exam and manner stated.	knowledge, death ination and/or inv	occurred at the estigation, in my	time, date and p y opinion, death (	place, and due to the caus occurred at the time, date	se(s) and manner as s and place, and due t	tated. o the cause(s)
)	To th withir To th comp	Me	29b. Signature and title of certifier	lung		29c. Lice	3726		. Date signed (Month,	
2			30. Name and address of person who con	mpleted cause of death (I	tem 23a) (Type, F	Print)				
	Sta	10	31. Date filed (Month, Day, Year)	32. Registrar's Sir	9'500 K	144 Ale	icis nd	(Anha	~ 2 ·	+06
9.	Sta Registr		FEB 0 4 2008	32. Registrar's Sig	goods!					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 8, 2008 **Physician** Helen Heffner Blickenstaff 2:45 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Golden Living Center Frederick Frederick 8. Date of Birth (Month, Day, Year) Feb. 27, 1912 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2√2 F 218-34-2858 95 Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits notified at Frederick Frederick 1 XYes 2 No Marvland Director 28a-f 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a or Examiner must be r 30 North Place 21701 U.S.A. Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
nt; If item 27 Is marked other than "natural", or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: White Completed by XXWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry event, the Medical College (1-4or 5+) Elementary/Secondary (0-12) Owned and Operated Grocery Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Bernard Myers Maud Mae Heffner ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8820 Bay Ridge Blvd., Orlanda, FL Mrs. Jean B. Galloway, daughter 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XX Burial 2 □ Cremation 3 □ Removal from State Mount Olivet Cemetery Feb. 12, 2008 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee <sup>2</sup>Keeney and Fastord PA Funeral Home MO0255 106 East Church Street, Frederick, MD 21701 s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complicati shock, or heart failure. List only one of Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nunsequents of) Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an COLON autopsy performed? Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ု 1 🗍 Inpatient 2 ER/Outpatient 3 □ DOA After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral 🛮 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, D0036610 56 Thomas Johnson Dz, Frederick inD 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup>11, 2008 **Physician** 7:15 p.M February Neal Pendleton Baker /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford UpperChesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/27/1954 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1X M 2 □ F Maryland 53 215-50-9559 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Harford Aberdeen 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21001 U.S.A. 215 Hemlock Lane Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∐Yes 2½ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 200 No Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Computers Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barbara H. Harward Charles W. Baker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 Hemlock Ln. Aberdeen, MD Barbara H. Baker 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 2/13/08 West Chester, PA 4 □ Donation 5 □ Other (Specify) R. A. Ferris & Co. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part 1. Enter the disease, or corp lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 □Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Be ို Certification:

/Medical Examiner attending physician and for use as the burial-tran Box 68760. Division or Vital Records,

**Funeral** 

**Director** 

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

with the Maryland

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Maryland 21215-0036

Baltimore,

Pages '

**Physician** 

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						1□ Yes	2 <b>1</b> 0 No	1 ☐ Yes	2□No	
25. Was case refer	red to medical				26. Place of De	eath (Check only o	one)			
examiner? 1 ☐ Yes 2	No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 🗆 D0	OA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)				
27. Mann r of Deatl 1 ─ Natural 2 □ Accident	n 5  ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury	occurred		
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, stree y)	t, factor	y, office	28f. Location ( City or To	Street and wn, State)	Number or Rui	ral Route Number,	
29a. Certifier (Check only		ysician: To the best of my kno niner: On the basis of examina								

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical

08-01112 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Aaron Robert Brink 2008 04769 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death Physician/ Decedent's Name (First, Middle Last) Month Medical Examiner 0204 hrs AARON ROBERT BRINK February 8, 2008 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Chester River Hospital Center Chestertown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 6. Sex **Funeral** New York Months Days Hours Min Director July 9 1970 212-17-8485 37 1 XM 2 F Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. Count Worton MD Kent items 23a or 28a-f shoust be notified at once. Director 10f. Zip Code 10g. Citizen of What Country 10e Street and Number 25119 Still Pond Neck Rd. 21678 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If item 27 is marked other than "natural", or items her traumatic event, the Medical Examiner must be Armed Forces? White, etc. 1 Never Married 2 X Married 2 X No Yes White f Yes, Give Year Yes 2 X No specify: be filed within 72 hours after Widowed Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Baltimore, MD 21215-0036 Fibreglass Boat Repairman Marina permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Com 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eileen VanderWerf Robert S. Brink Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21678 19a. Informant's Name/Relationship (Type, Print ) 25119 Still Pond Neck Rd. Worton, MD. Shelley Brink (wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Still Pond Cemetery 2/13/08 Smyrna, DE. Donation 5 Other Specify 2. Name and Address of Facility alena Funeral Home of Step 18 West Cross St. Galena, 21. Signature of Funeral Service Licensee Stephen L Schaech 21635 M00510 MD. Approximate Interval Per I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical a. Methadone intoxication and cocaine use Immediate Cause (Final disease `xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and ed for use as the burial - transit Physician/Medical X UNPENDED 28a-f, perME, 9877 3/6/08 TI 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Ectopic pregnancy Live birth detached for use as Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of has performed? death? ✔ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Other 4 Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 Other 1 V Yes No 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury Certification

Yes 2 X No

Death

2 No

28f. Location (Street and Number or Rural Route Number, City

29d. Date signed (Month, Day, Year)

24698 Smithville Rd Worton, MD

February 8, 2008

Division of Vital Records, P.O. Box 68760, After this certificate the Hospital or Attending Physician: Itin 24 hours after death. Notified 24 hours after uses...

To the Funeral Director: Africator: Africator in by the fu

Natural

Accident

Suicide

29b. Signature and title of certifier

29a. Certifier 1

g

State

Registra

Pending

6 X Could not be

Investigation

determined

Jonna MU incenti, MID 30. Name and address of person who completed cause of death (Item 23a)

Donna M. Vincenti, MD Assistant Medical Examiner

31. Date filed (Month, Day, Year) FEB 16 32 Registrar's Signature 2008 OCME **ORIGINAL** 

Fnd 2/8/2008

(Specify)

and manner stated

FNd 12:52

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28e. Place of Injury - At home, farm, street, factory, office building, etc.

found at home

1 Yes 2 X No

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

unk

		1- For State Registrar	С	ertificate o	f Death			Reg. No. O	(008.	04/10
Physici	an/	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day								3. Time of Death
ledical Exami	ner	Ferne Carol C	~							1545 hrs
		4a. Facility Name (if not instituti	on, give street and number)		4b. City, Town, or	Location of Deat	h		ounty of Death	1
		3900 Gregg Road			Brookville				ntgomery	
Funeral		5. Social Security Number	D. D. T.	s. last birthday)	If Under 1 Year Months Days		_		The section	thplace (State or
Director	9 E	577-70-6196	1 M 2 X F	59 <sub>Yr</sub>		I louis Iviii	07/2	8/1948	Co	ountry) DC
		Usual Residence of Decedent								
w any		10a. State 10b. County		ity, Town or Loca						10d. Inside City Limits
land f sho	ō	DC	Wa	shingto	n 					1 X Yes 2 No
Mary 28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citizer	n of What Cou	ntry?
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ms 2.	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?		as Decedent of His Yes, specify Cuban			No- 14	. Race - Amer White, etc.	ican Indian, Black,
deati or ite	'n	1 Never Married 2 X	1 Yes 2 X No				o Nican, etc.)		write, etc.	
after al",	by		ivorced If Yes, Give Year or Dates:		Yes 2 X No				pecify: Whit	
5-0036 led within 72 hours it ygiene. other than "natur;			ecify only highest grade completed	16a. Decede during n	nt's Usual Occupat nost of working life.			16b. Kin	d of Business/	Industry
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medical	To Be	Aris Carpousi 19a. Informant's Name/Relation		10h Mailir	ng Address (Stree	Mary He		Number City	or Town State	Zin Code)
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after Department of Health and Mendal Hygiene Important: If item 27 is marked other than "natural", or injury or other traumatic event, the Medical Examiner I	Ĥ	Eric Hompe /			18th St.					5, 21p Gode)
and 2 ealth tem 2 traun		20a. Method of Disposition			sition (Name of cer		Date		cation - City or	Town, State
Ore ges 1 t of H ther		1 Burial 2 X Crematic	on 3 Removal from State	crematory or o		2/1	8/2008		7 04	
timent timent tant:		4 Donation 5 Other 9	op cony.		Crematory	7		Fal		rch, VA
Bal Sermin Separ Mpon		21. Signature of Funeral Service	D Housley		Name and Address		-			
			or complications the caused the dea		130 Wisco					Approximate Interval
Physician /Medical	Ш	failure. List only one caus	e on each line.	ath. Do not enter	the mode of dying,	Sucri as Cardiac	orrespiratory	arrest, snock	, or neart	Between Onset and
Examiner	(T) (Z)	Immediate Cause (Final diseas or condition resulting in death)	***************************************							Death
			Due to (or as a consequence	e or):						
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ecute C			d. AMENDED 23a,27,3	28a=f por	ME 0878 /1/	15/08 amb				
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776 ficate g phy s the t	Ž	IF FEMALE: 23b. Was decedent pregnant in	the 23c. If yes, outcome of pr			Estania progr			Date of deliver Ionth	•
Sox 687 leath certific e attending properties as t	ciar	past 12 months?	the 1 Live birth 4 Pregnant at time of	dooth	etal death 3 other (Specify)	copic pregr	lancy	101	ionin	Day Year
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ds den	Completed						24a. W			utopsy findings available
Record The law recate has be bage 2 sho	ם						·   p	utopsy erform <u>ed</u> ?	death?	completion of cause of
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Sion Atten death actor:	cati	J Per	estigation Fnd 2/11/08	Fnd 5:20	n   _		Subject	t placed	plastic	bag over head ural Route Number, City
Division pital or Attendi ours after death.	#		uld not be 28e. Place of Injury - A		eet, factory, office b	building, etc.	or Tow	on (Street and n, State)	Brookvi	ural Route Number, City
Hospita 24 hours Funeral fille		4 Homicide	Tourid 1							
To the Hospital Within 24 hours To the Funeral	<u>ca</u>	(Check only   Certifying i	Physician: To the best of my knowled aminer:On the basis of examination							
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V			U WI.		O.C.	ıvı.⊑.		Febru	uary 12, 20	
			7 /0 //							
			on who completed cause of death (II		Ot	time and AAD C	11001			
		Jack Titus MD. De	eputy Chief Medical Examir	ner 111 Pe	nn Street, Bal	timore, MD 2	21201			
St Regis	ate		eputy Chief Medical Examir	ner 111 Pe	nn Street, Bal	timore, MD 2	21201			

State of Maryland / Department of Health and Mental Hygiene

Ferne Carroll Carpousis

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State of Maryland / Department of Health and Mental Hygiene

2008

		1- For State Certificate of Death	Reg.	No.							
Physici Mediçal Exam		1. Decedent's Name (First, Middle,Last)	2. Date of Death	av Year	3. Time of Death 1730 hrs						
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 409 Laurel Wood Drive Lonaconing	Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. Cou.  409 Laurel Wood Drive Lonaconing Garre								
Funeral Director		5. Social Security Number  6. Sex 7. Age (In yrs. last birthday)  1. Age (In yrs. last birthday)	8. Date of Birth	Co	thplace (State or Foreign untry)						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland Garrett  10c. City, Town or Location  Lonaconing  10c. Street and Number  409 Laurel Wood Drive  21539  11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  1	ecify Yes or No-Rican, etc.)  ork done ed)  (First, Middle, Ma Andrews tural Route Numbe  Thurm	U.S.A.  14. Race - Ameri White, etc.  Specify: Whi 6b. Kind of Business/liden Surname)  er, City or Town, State ont, Mary1 20c. Location - City or	10d. Inside City Limits  1 Yes 2 No  ntry?  can Indian, Black,  te  ndustry  2 Zip Code)  and 21788  Town, State						
Baltimore, permit. Pages 1 a Department of He Important of He Important: If it injury or other to	ner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):	SON FUNITHURMON	ERAL HOMES	, Maryland , P.A. D 21788 Approximate Interval Between Onset and Death						
Box 68760, c death certificate be executed the attending physician and ed for use as the burial - transit	ian/Medical Examiner	UNPENDED AMENDED  IF FEMALE: 23b. Was decedent pregnant in the	псу	23d. Date of deliver Month	y Day Year						
, P.O. Box 687 ires that the death certific signed by the attending I be detached for use as the	by Physiciar			acco use contribute to	the cause of death?						
Sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed cleath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transi	To Be Completed	25. Was case referred to medical examiner?  1 ✓ Yes 2 No Other 1 Inpatient 2 ER/Outpatient 3 DOA Other 1 Nursing 27 Manner of Dooth 28c Date of Injury 28c Injury 28	24a. Was an autopsy perform 1 ✓ Yes 2 ponly one)	24b. Were at prior to death?	utopsy findings available completion of cause of es 2 No						
Division or Attending ours after death.  eral Director: At filled in by the fun	ertification:	1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 4 Homicide 1 Homicide 1 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Single Family	or Town, Sta	reet and Number or Ru	ural Route Number, City						
Divi To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical Ce	20a Catifier	due to the cause(	s) and manner as stat	ed.						
E is E 8	Me	29b. Signature and sitle of certifier  After Drank M  O.C.M.E.		29d. Date signed (Mo							
10		30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201								
S Regis											

**Physician** /Medical Examiner Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. Physician/Medical signed by the a Completed by certificate To the Hospital or Attending Physician: After this certific funeral director, Be Medical Certification: To death. Director: filled in by efter 24 hours e

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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permit. Pages 1 and 2 Department of Health at Importent: If item 27 is any injury or other tratons.

Director

Completed by Funeral

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other traumatic event, the Mudical Exeminer must be notified at

the Maryland

Pages 1 and 2 should be fited within 72 hours after death with

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

8+1VA

within 2

completely

Sachder 31. Date filed (Month, Day, Year) State 2008 Registrar

29b. Signature and inte of certifier

118 Nost 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number 10023322

Sute 3B

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day **Physician** Paul Charles Carpegna 4 2008 11:50P M Feb. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1914 Maplewood Drive Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 11/05/1926 Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Hours Months 1 X M 2 □ F 219-20-2682 Yrs. Director MD 81 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28s-f show traumatic event, It a Madical Examinar must be notified at Director MD 1 ☐ Yes 2 No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 1914 Maplewood Drive US Iteme 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Menial Hygiene. Int: If Item 27 Is marked other then "natural", or Ite Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Completed by Spacify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Vice President Furniture Manufacture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sabatino (unk) Carpegna Antonia (unk) Castaluchi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy J. Carpegna / Wife 1914 Maplewood Drive, Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. Cedar Lawn Mem. Park 02/09/2008 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** azci'y oma hostale /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physicien: The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death signed by the aid 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cete has been sign. page 2 should t 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes funeral director. Be 25. Was case referred to medical 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) 1 ☐ Yes 2 Ø No 1 Inpatient Medicai Certification; To this 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of After 28d. Describe how injury occurred Injury 1 Matural 5 Pending within 24 hours after death. To the Funerel Director: A investigation 1 Yes 2 No М 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospitel 1.2 Certifying Physician: The best of my knowledge, dath occurred at the time, date and place, and due to the eausu(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completely (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D21457 2/6/2008 My Local W1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAGERSTOWN. WATERD 12821- OAKHIL AVE 5H-8+1 MID. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB Registrar 08 2008

State Registrar 30. Name and address of person

Alejandro'.

31. Date filed (Month Day, Year
FEB 0

DHMH 17 Rev 1/2001

uning ham Ji

2401 W. Belvedere Ave Balto ND 21215

who completed cause of death (Item 23a) (Type, Print)

32. Radistrar's Signature,

MD

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2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

sician edical miner		Guy Togonh C	olella, Jr.					2. Date of De Month	Da			of Death M
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		Arcola Health & Rehab  5. Social Security Number 6. Se		ast hirthday)	If Under		If Under 24 Hrs	8. Date of Bir		0.5:		or Foreig
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	-	10a. State 10b. County	10c. City	, Town or La	cation						10d. Inside (	
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Director	Ď	10e. Street and Number			10f. Zip	Code			10g. Ci	tizen of Whal C		
		1610 Gridley La				902				USA 14. Race - Am		
Firegra	2	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Deced If Yes, spec	ent of His rly Cuban	panic Origin? (S , Mexican, Puer	pecify Yes or No to Rican, etc.)	)-	Black, Whi		
24		1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 <b>∑</b> No If Yes, Give Year or Dates:		1 ☐ Yes 2	No No	Specify:			Specify: V	White	
		15. Decedent's Ed	ucation	16a. Dece	dent's Usua	I Occupat	ion		16b. K	Kind of Business	/Industry	
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Completed	5	9	ounogo (* *o**o**)	Medi	cal E	quip	nent Rep	pair		NIH	<u> </u>	
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C		Guy Joseph Colel	la, Sr.				Josep	ohine De	mma			
		19a. Informant's Name/Relationship (7 Anna M. Colella						Silver				
		20a. Method of Disposition	20b. Pl	ace of Dispo emetery, crer	sition (Nam	ne of ther place	Fel	Date 7,	20c. L	ocation - City o	Town, Slate	
		xxBurial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Removal from State	e of H			. '	2008	Sil	lver Spi	ring, M	la <b>r</b> y
OUCE.	T	21. Signature of Funeral Service Licen	588	F 22	2. Name and	d Address	of Facility	Funeral	_			
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leted by Physician/Medical Examiner	LYall	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Gangrene of I Due to (or as a consequ c	ience of):								
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Physician/Medi	iyaiciairw	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3	Ectopic pro					23d. Date of de Month	Day	Year
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0		examiner? 1  Yes 2x No	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatier	nl 3 🗆 DO	Othor		Home 5 Res		6 ☐Other (Sp.	ecify)	
i		27. Manner of Death		28b. Time o		8c. Injury Work	at	28d. Describe	how inju	ury occurred		
ortification.	II Call	1xGNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho	me, farm, sti	M reet, factory	1 🗆 Y	es 2 □No			nd Number or F	Rural Route Nu	ımber,
C	۱ د	4   nomiciae	building, etc. (Specify					City or To			an stated	
Paripa	מונים	29a. Certifier  (Check only one)  1 Certifying Physical Exemption (Check only one)	iner: On the best of my know iner: On the basis of examinat and pranner stated.	wiedge, deat tion and/or in	h occurred vestigation,	at the time , in my opi	nion, death occ	e, and due to the urred al the time	date ar	nd place, and du	e to the cause	)(S)
2	_	29b. Signature and title of certifier	// //		290	. License				ate signed (Mor		
		) BA	Kacesta				d09834			February	4, 20	
		30. Name and address of person who of Barry Rosenbaum, 1						3/15 (	0000	5		

08-01121 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 Terrence Randolph Colvin State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Medical Examiner Terence Randolph Colvin 1054 hrs February 8, 2008 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Deatl Prince George's 6009 Sarvis Avenue Riverdale 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex **Funeral** Months Days Hours Director 220-42-3636 62 March22,1945 Country) England 1 X M 2 F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 No Maryland|Prince George's Riverdale Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6009 Sarvis Avenue 20737 United States 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 If Yes, Give Veretnam War Divorced 1 Yes 2 X No specify Specify. White \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) d other than " the Medical J Lab Supervisor Flintrock Ink Co. MD 21215-0036 Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Randolph Charles Colvin Eva Christine Tredgett item 27 is marked 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William F. Colvin -brother 9619 Cortland Lane Dunkirk, Maryland 20754 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, crematory or other place)
Metropolitan Crematory2/9/2008 1 Burial 2 Cremation 3 Removal from State Alexandria, Virginia 4 Donation 5 Other Specify Ponara Voca Borgwardt Funeral Home, PA 21. Signature of Funeral Service Licens to 4400 Powder M<u>ill Road Beltsville.</u> homas. Maryland 20705 UW 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Seizure Disorder Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. ine if any, leading to immediate Due to (or as a consequence of). cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED 1,23a,27,28a-f per ME g878 4/23/08 amh X UNPENDED attending physician of the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Yes 2 ✓ No 3 Probably 4 Unknown Completed certificate has been 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of death? performed? 2 No ✓ Yes 2 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene this 1 ✓ Yes 28b. Time of Injury UNK After 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) Unk 27. Manner of Death Certification: Natural Yes 2 X No Pending within 24 hours after death Director: Subject fell 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) (Specify)Other-Dwelling 009 Sarvis Ave Riverdale MD To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ca 2 Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 9, 2008

State Registra

-

30. Name and address of person who completed cause of death (Item 23a)

2008

OCME

David Fowler M.D.

31. Date filed (Month, Day Year)

EB 1 4

Chief Medical Examiner

Registrar's Signature

PAR

111 Penn Street, Baltimore, MD 21201

08-01219 Tina Chase

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	48	Anne Arundel Medical Center  4b. City, Town, or Location of Death Annapolis		Anne Arunde								
	_	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. If	Date of Birth (M	M/DD/YYYY) g. Bi	rthplace (State or							
Funeral Director	5.		Sept. 3		ountry) Maryland							
<b>b</b>	_	Usual Residence of Decedent  10c. City, Town or Location  10d. Inside City  10d. Inside City										
and show any nce.		MD Anne Arundel Lothian	1100	1 Yes 2 X No								
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	1 I	82 4th Street 20711		Citizen of What Co U.S.A								
eath with items 23 ust be no	1	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1	y Yes or No- an, etc.)	c.) white, etc.								
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21215-0036 Mental Hygiene. Marked other than ic event, the Medica	5	17. Father's Name (First, Middle, Last)  18.Mother's Name (First, Middle, Last)										
215 be file ntal H rrked o	8	Gary Marlan Anderson Barbar  10a Informant's Name/Relationship (Type, Print )  119b. Mailing Address (Street and Number or Rural		bard	ete Zin Code)							
D 21215-00; should be filed with and Mental Hygiene in marked other in matic event, the Mental House in the Head of the filed other in the Head other in the	^ ا≏	19a. Informant's Name/Relationship (Type, Print)  Gary M. Chase, husband  19b. Mailing Address (Street and Number or Rural 82 4th Street, Lothia			20, 21, 2000)							
ore, MD Stand 2 show of Health and If item 27 is her traumatin		20b. Place of Disposition Da	ate 2	0c. Location - City	or Town, State							
Baltimore, ME permit Pages I and 2 submit Pages I and 2 submitment of Health a Important: If item 27 injury or other traum.		Described 2 X Cremation 3 Removal from State    Crematory or other place   Removal from State   Crematory 02/1	5/08	Alexandr	ia, VA							
iltim nit. Pa artmer ortani		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rails	usch Funeral Home, P.A.									
Dep Dep		8325 Mt. Harmony La	ane, Owi	ings, MD	20736 Approximate Interval							
hysician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resfailure. List only one cause on each line.	spiratory arrest,	, SHOCK, OF HEAR	Between Onset and Death							
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Box 687 e death certific the attending p	Physician/	past 12 months?  4 Pregnant at time of death 5 Other (Specify)			3							
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that ters after death "In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted.	Certification:	Accident Investigation Suicide Investigation Suicide Investigation Suicide Investigation Suicide Investigation Suicide Investigation Suicide Investigation Suicide Investigation Suicide Investigation Suicide Investigation Suicide Suicide Investigation Suicide Sui										
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Division of Vital Records, P.O. Box  To the Hospital or Attending Physician: The law requires that the death within 24 hours after death To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for u	e(s) and manner as and place, and due	to the cause(s)										
To t vith com		(Month, Day, Year)										
	(Check only one)  2 Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause and manner stated.  29b. Signature and title of certifier  29c. License number  O.C.M.E.  Pebruary 12, 2008											
		30. Name and address of person who completed cause of death (Item 23a)  Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201									
St	ate	Tubild Creenberg in 2										
Regist		31. Date filed (Month, Day Year) 5 2008 32. Refistrar's Signature										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 9:55a 1,2008 Chase February John /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Mechanicsville Marys 40815 King Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/11/1929 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1**X** M 2□F 78 Maryland 213-22-0471 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 □ No Director Mechanicsville Maryland St. Marys 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 40815 King Drive 20856 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Black, White, etc. e filed within 72 hours after oal Hygiene. al Hygiene. I **other than "natural", or Iter** Armed Forces.
1 X Yes 2 □ No
If Yes, Give
Year or Dates: 1951-53 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify. Black Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Charlotte Hall College (1-4or 5+) Elementary/Secondary (0-12) Veterans Home 12 Dietician Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event; i once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 12 should be find and Mental H Mary John Henry Chase Spears 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 0 7 4 4 19a. Informant's Name/Relationship (Type. Print) Washington, Maryland Gwendolyn Jackson/daughter 6101 Brandyhall Ct. Ft. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Leonardtown, Maryland Charles Memorial 2/9/08 21. Signature 22. Name and Address of Facility Adams Funeral Home PA 20605 Aquasco Rd. Aquasco, Maryland 20608 Approximate Interval Between Onset and Death eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician ٤ disease or condition resulting in death) /Medical Due to (or as a of): **Examiner** Sequentially list conditions, Due to (or as a con-Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, physician IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ned by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death Check onl one Medical Certification: To Be Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 🖥 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 € No 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, Hospital or Attending Physician: s after dea.
rai Director: Aftr

within 24 hours after dea

To the Funeral Directo

completely filled in by th 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier se of death (Item 23a) (Type, Print) 30. Name and add Hollywood 31. Date filed (Month, Day, State FEB 05

29d. Date signed (Month, Day, Year)

State

FEB 0 6 2008 Signature - 32. Registrar's Signature - 32. Registrar's Signature - 33. R

Peter L. Wisniewski MD

Registrar

10845 Town Center Blvd., Dunkirk, Maryland

20754

08-00737

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 0478 Kirra Marie Cosby Certificate of Death 1- For State Reg. No. 3. Time of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day January 26, 2008 Physician/ 0554 hrs Medical Examiner Marie 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Johns Hopkins Hospital If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) | 9. Birthplace (State or 7. Age (In yrs. last birthday) Foreign ARIZONA Country Rizona 6. Sex 5. Social Security Number Funeral Months Days Hours Director 996 M 2 V/F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No 'ambridge Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene. 10g. Citizen of What Country **Funeral Director** 10e. Street and Number USA Green Woo Race - American Indian, Black, Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. event, the Medical Examiner must be Armed Forces? 1 Never Married 2 V No Yes Specify: Black 1 Yes 2 No specify: If Yes, Give Year 4 Divorced 16b. Kind of Business/Industry "natural", 16a. Decedent's Usual Occupation (Give kind of work done ⋧ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Elementary School MD 21215-0036 marked other than Student 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ermeshia Be SSell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) If item 27 is m ther traumatic e Apt. 302 Cambridge MD.21613 Greenwood Kermeshia 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Baltimore, 1 Burial 2 Cremation 3 or other Cambridge. 2/2/08 Department of Important: I J.R. Briscoe Men. Park Donation 5 Other Specify 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

23. Name and Address of Facility

24. Henry Funeral Hone, P.A.

25. D. Washington St. Cambr. de.

23. P. 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such is cardiac or respiratory arrest, shock in 21. Signature of Funeral Service Licensee Approximate Interva Between Onset and Physician ailure. List only one cause on each line Death Medical a. Head and Neck Injuries Immediate Cause (Final disease .aminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending nhysician and Physician/Medical physician a the burial - 1 AMENDED UNPENDED 23d. Date of delivery O. Box 68760 23c. If yes, outcome of pregnancy IF FFMALE: Year Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 V No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? is been signed by the should be detached contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 1 Yes 2 No 3 Probably 4 V Unknown \$ Division of Vital Records, P. 24b. Were autopsy findings available Completed 24a, Was an prior to completion of cause of autopsy performed? death? Nο 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Other 4 Residence 6 Other Nursing Home 5 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury Subject passenger of vehicle in vehicular 27. Manner of Death Certification: Jan 25, 2008 1612 hrs Yes 2 V No Natural accident Pending the 28f. Location (Street and Number or Rural Route Number, City 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. filled in by or Town, State) Rt 50 & Rt 213, Wye Mills, Md Could not be Suicide determined (Specify) roadway Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely Medical one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME January 28, 2008 O.C.M.E. 30. Name and address of person who completed cause of do-

State Registrar

Theodore M. King, Jr., MD. 31. Date filed (Month, Day, Year) 0



# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 04783

	1- For State Registrar	Cer	rtificate of De	eath		Reg	g. No.		
Physician/	Decedent's Name (First, Middle,La	n Day Year	3. Time of Death 1010 hrs						
Medical Examine		, 2008 4c. County of Deat							
1	4a. Facility Name (if not institution, g Maryland Rte 4 at Thoma			rince Frede	ocation of Death		Calvert		
Funeral		Sex 7. Age (In yrs. I	ast birthday) If	Under 1 Year	If Under 24Hrs	8. Date of Birth	n (MM/DD/YYYY) 9. B	rthplace (State or	
Director	216–15–4966	ζM 2 F 30		nonths Days	Hours Mir	07-07	_1977 Fore	ountry) Maryland	
	Usual Residence of Decedent	10.00	<del></del>					10d. Inside City Limits	
w an)	10a. State 10b. County		, Town or Location					1 Yes 2 X No	
Varyland 28a-f show any i at ouce, ect or	MD Calver	t St	<ul> <li>Leonard</li> </ul>	f. Zip Code		10	g. Citizen of What Co		
the Maryland a or 28a-f sh tiffed at ouc	1550 Ave. B			20685			United St		
with the lis 23a re noti	11. Marital Status	12. Was Decedent Ever in U		ecedent of Hisp		pecify Yes or No-	14. Race - Ame	erican Indian, Black,	
er death with , or items 23.	1 X Never Married 2 Marrie	Yes Z Y No	If Yes, s	specify Cuban,	Mexican, Puerto	o Rican, etc.)	White, etc.	• •	
rs after	3 Vildowed 4 Divorce	ed If Yes, Give Yaar or Dates:	s, Give Yaar 1 Yes			d. dana	Specify: White		
hours "natu" Exan	15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. Decedent's L during most of		DO NOT use ref		Tob. Kind of Business	s, mudett y	
5-0036 ed within 72 hour lygiene. other than "natu he Medical Exar	Library, coordinately (o 12)	2	Automob	ile Tec	hnician	l	Mechanic	Automotive	
5-0( led wi offer offer Cor		et)				e (First, Middle, M			
d be fill fental Finarked event, Be	Marvin Leonard C		10h Mailing Ad			Joan Lo	ong ber, City or Town, Sta	te Zip Code)	
ID 21 2 should and Me 27 is mar matic ev	Marvin L. Coon,						ryland 206		
e, N 1 and 3 Health item 3	20a. Method of Disposition	20b.	Place of Disposition crematory or other	(Name of cem	etery,	Date	20c. Location - City of		
imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Iant: If iten 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	1 Burial 2 X Cremation 3 4 Donation 5 Other Specia	Removal from State	etropolita	,	atory 2,	/14/08	Alexandr	ia, Virginia	
Baltimore, MD 21215-0036  pewnit. Pages I and 2 should be filed within 72 hours after death with the Maryland Denarment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	21. Signature of Funeral Service Lic		22. Name	and Address	of Facility R	ausch Fu	neral Home		
	23a. Part I. Enter the disease, or cor	evillations that assess the death	P. Do not optor the m	O. Box	600, I	usby, Ma	aryland 206	Approximate Interval	
Physician / Medical	failure. List only one cause on	each line.	1. Do not enter the n	loge of dying, a	30011 03 001 0100	or roopmatory arre	,	Between Onset and Death	
taminer	Immediate Cause (Final disease or condition resulting in death)	Multiple Injuries  Due to (or as a consequence of	of):						
	Sequentially list conditions,	D	-4\.					_	
nine nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence of							
ted Insit	events resulting in death) Last	Due to (or as a consequence of	of):						
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760, cate be physic he bur	IF FEMALE:	23c. If yes, outcome of preg	gnancy				23d. Date of deliver		
lox 687 eath certific eath certific s attending process the	past 12 months?	1 Live birth Pregnant at time of d	2 Fetal o	leath 3 ( (Specify)	Ectopic pregr	ancy	Month	Day Year	
Box 68  death certif the attending ed for use as hysician	1 Yes 2 No 9 Unkno		5 Other	(Opecity)			110.		
P.O. Be es that the des igned by the se detached for the second by the second by the second by the second for the second by Physical by Ph		contributing to death but not	resulting in the unde	erlying cause gi	iven in Part I.			to the cause of death?	
1 of Vital Records, P.C. Jing Physician: The law requires that After this certificate has been signed funeral director, page 2 should be det						24a. Was		autopsy findings available	
Records, The law requires freate has been sig page 2 should bb Completed						autop		o completion of cause of	
Rec The L						1 ✔ Yes			
ital itial itian;	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	ER/Outpatient 3		of Death (Chec		Residence 6 V Ott	ner: Scene	
of Vi		28a. Date of Injury	28b. Time of Injur		y at Work?	28d. Describe	how injury occurred		
on on ending sath.	1 Natural 5 Pending		1000 hrs	1 Y	es 2 🗸 No	Operator of	motorcycle-moto	or vehicle collision	
Division of Vital Records, spltal or Attending Physician: The law require sorus after death.  Beral Director: After this certificate has been sinfilled in by the funeral director, page 2 should be Certification: To Be Completed	2 Accident Investig 3 Suicide 6 Could n	28e Place of Injury - At h	nome, farm, street, f	actory, office bu	uilding, etc.	or Town, S	State)	Rural Route Number, City	
Dj Spital nours a neral l	4 Homicide determin	(apaciny) Wajor Noc				Maryland Rte	4 at Thomas Johns	son Bridge, Solomons,	
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical Experimental Cortification:		ician: To the best of my knowled er:On the basis of examination	dge, death occurred and/or investigation	at the time, da , in my opinion,	ite and place, ar , death occurred	at the time, date	se(s) and manner as st and place, and due to	the cause(s)	
To t To t com	29b. Signature and title of certifier	and manner stated.	-	29c. License			29d. Date signed (A		
	Caral 1	Hallan	_	O.C.N	И.E.		February 8, 20	08	
-/	30. Name and address of person wh					0.1	· · · · · · · · · · · · · · · · · · ·		
9		tant Medical Examiner	111 Penn Str	eet, Baltimo	ore, MD 212	01			
State Registra		2008 32. egistrar's Signar	SCO.4						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 Harriet Elizabeth Cave February РМ 2:10 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Golden Living Center If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year May 6, 192 Birthplace (State or Foreign Country) 5. Social Security Numbe 216-80-2548 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F 82 Canada Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Frederick Frederick 1 ☐ Yes 2 X No Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 507 Postoak Road 21703 United States Funeral 72 hours after death 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2**X**ÎNo Specify: White è 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Beech Mansfield Young Harriet Elizabeth Onions ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) s 1 and 2 of Health a item 27 is 507 Postoak Road, Frederick, Maryland 21703 Rae Duckworth / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 a February 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Smithsburg, Maryland Smithsburg Crematory 11, 2008 4 ☐ Donation 5 ☐ Other (Specify) <sup>22</sup>, Name and Address of Facility
Keeney & Basford P.A. Funeral Home
106 East Church Street, Frederick, MD 21701 21. Signature of Funeral Service Licenses M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CENTBRAL Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MARIVE Se juentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examine certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 5 ☐ Other (specify) ed by the a 9☐Unknown 9 ☐ Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 autopsy performe certificate has 1□ Yes 2 No Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 1 🗀 Yes 2010 2 ER/Outpatient 3 DOA 4 ☐ Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Whatural Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760 P.O. I Division or Vital Records,

To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral

to the catifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number D47951

29d. Date signed (Month, Day, Year)

February 11, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sibte Kazmi M.D. 814 Toll House Avenue, Frederick, Maryland 21701

State Registrar

Medical

29a. Certifier

(Check only

31. Date filed (Month, Day, Year) FEB 16 2008



08-01145		Please Type or Print						ble.			
Heaven Cannon	F	- For State	yland / Depar <i>Certi</i>	tment of He ificate of De			Reg.	No. 2	008 0478		
Physiciar Medical Examin	"	1. Decedent's Name (First, Middle, Last) Heaven Nevaeh C				Date of Death Month [ February 9,					
to the		4a. Facility Name (if not institution, give street and Dorchester General Hospital	d number)	4b. City, Town, or Location of Death Cambridge							
Funeral Director	1	5. Social Security Number 6. Sex	7. Age (In yrs. ias	Mo	nder 24Hrs. 8	Feeder					
	- 15-	Usual Residence of Decedent		Yrs.	1 12	10d. Inside City Limits					
Ind show any are.	-	MD 10b. County Dorchester		own or Location Iurlock					1 Yes 2 X No		
LECT A	2	10e Street and Number 4948 Skinners Run	Road	10f.	Zip Code 2 ]	1643		Citizen of WI	hat Country? States		
r a de	E L			If Yes, sp	edent of Hispanic C ecify Cuban, Mexic 2 X No speci						
ours aft atural"		15. Decedent's Education (Specify only highest		16a. Decedent's Us		ve kind of wor		16b. Kind of Business/Industry			
5-0036 led within 72 h Hygiene. I other than "n the Medical E	Completed	Elementary/Secondary (0-12) Colleg	je (1-4 or 5+)	N/A	•			N/A			
215-0 be filed w ntal Hygic rked othe	S Be	17. Father's Name (First, Middle, Last)  John Gallagher			irst, Middle, Ma a Nico						
ID 21 2 should 1 1 and Mer 27 is mar matic ev	2	19a. Informant's Name/Relationship (Type, Print Tonya M. Newcomb/Grand			ess (Street and N inners Ru				vn, State, Zip Code) 21643		
ore, M es 1 and 2 of Health; Hitem 2'	Ī	20a. Method of Disposition  1 X Burial 2 Cremation 3 Remov	20b. Pl	ace of Disposition ( ematory or other pl hington (	ace)	02/15	i		- City or Town, State		
Baltimore, permit. Pages I an Department of Hel Importanti. If ite	1	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		com Funeral Home, P.A. ralsburg, MD 21632							
m ឱ្ង≝≣ Physician	1	23a. Part I. Enter the disease, or complications the		216 N Do not enter the mo	. Main St	s cardiac or re	lera1sb	urg, MI	eart Approximate Interval		
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execut an and al - tra	<u>8</u>	d		perME.g877	3/12/08 TT	-					
8760, tificate build physical as the build as the build buil	n/Me	IF FEMALE: 23c. If y	res, outcome of pregnative birth	ancy 2 Fetal de		opic pregnanc	;y	23d. Date of Month	f delivery Day Year		
P.O. Box 68760, that the death certificate be need by the attending physici detached for use as the buri	Physician/Med	4 Vac 2 d No 9 Unknown 4 P	regnant at time of dea nknown	th 5 Other (	Specify)						
i, P.O. ires that the signed by t	6	Part II. Other significant conditions contributi		o use contribute to the cause of death?  No 3 Probably 4 Unknown							
of Vital Records, ing Physician: The law require After this certificate has been si funeral director, page 2 should be	ompleted						24a. Was ar autops perform	y	Were autopsy findings available prior to completion of cause of death?		
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Vital sysician this cert directo	8	examiner?  1 ✓ Yes 2 No	Inpatient 2	ER/Outpatient 3	DOA Other		-	Residence 6	Other:		
on of nding Ph. th.	ion:	1 Natural 6 Denti-	Date of Injury Nonth, Day, Year) 2/9/2008	28b. Time of Injury FNd 6:22 a	28c. Injury at W		8d. Describe ho Ink	ow injury occur	rred		
Division tall or Attendible as after death.	Certification:	3 Suicide 6 X Could not be	me, farm, street, factory, office building, etc. 28f. L			St. Location (Street and Number or Rural Route Number, City or Town, State)					
		4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  MD  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  MD  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
To tl withi To tl	Medical	29b. Signature and title of certifier	o, o, i, i o o a gation, i	29c. License numb			29d. Date signed (Month, Day, Year)				
		30. Name and address of person who completed	cause of death (Item :	23a)	O.C.M.E.			February	10, 2008		
		Ling Li, MD Assistant Medical E	xaminer 111 l	Penn Street, B	altimore, MD 2	21201					
Sta Registr		31. Date filed (Month, Day, Year)   3.	2. Registrar's Signatur	& Speeds	A. C. C. C. C. C. C. C. C. C. C. C. C. C.						
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ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No.2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 2, 2008 **Physician** GEORGE TALCOTT DITTO 11:00 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Frederick Walkersville Glade Valley Nursing & Rehab. Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□M 2□F 83 1924 West Virginia Director 233-34-3693 16, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐Yes 2 ☐ No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or injury or other traumatic event, the Medical Examiner must be 21703 6599 Whetstone Drive U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ™ Yes 2 □ No If Yes, Give WWII & Year or Dates: Korea 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after by Hygiene. 1 Never Married 2 Married 'natural", or 1 ☐ Yes 2 ☐XNo Specify: Specify: 2 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien. Important: if item 27 is marked other the any injury or other trainmant. Supervisor Insurance Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hazel Jean Somers Talcott Eliason Ditto ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6599 Whetstone Drive, Frederick, Maryland 21703 Linda Sheppard / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Mem. Gardens 2/8/08 Frederick, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Emegal Service License 22 Name and Address of Eacility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. destar 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final 21 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** mass UN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): attanding physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Nes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform ospitai or Attending Physician: hours after death. uneral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27, Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29d. Date signed (Month, Day, Year) 29h. Signature and title of certifier 2008 EBRUANY person who completed cause of death (Item 23a) (Type, Print)

HVA

3altimore, Maryland 21215-0036

Box 68760.

P.O.

Division or Vital Records,

State Registrar

FEB 0 6 2008



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31. Date filed (Month, Day, Year)

30. Name and address of per-

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100 E. CALLOII ST.

32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Examiner

requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran P.O. Box 68760, Records, been Division or Vital this funeral After To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After filled in by the

**Physician** 

Examine

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercises

**Physician** 

/Medical

/Medical

Director

Funeral

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Completed

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Physician/Medical

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Certification: To

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IF FEMALE 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 27. Manper of Death 1 Natural 2 Accident Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certified 29c License number 0 0 0 2 4 0 6 4 29d. Date signed (Month, Day, Year) 215108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHANTHA MURTHY MD. 6196 0X0N HIU PD #520 0X0N HIU MT 20745

31. Date filed (Month, Day, Year, State

FEB 0 7 2008



Registrar

	1.	For State Registrar	State of	Marylan			of Health a of Death			ene g. No. 2 ()	08	04788	
Physician /Medica		Decedent's Name (First, Middle Anna Robbi							2. Date of Deatl Month <b>Pebruar</b>	Day	Year 08	3. Time of Death  2:15 a. M	
Examine:	5.	. Facility Name (If not institution Mallard Bay Social Security Number	Care Cente	Age (In yrs.	last birthday) Yrs.	Ca If Under 1	own, or Location of the combridge of the combridge of the combre of the	of Death  24 Hrs. 8	B. Date of Birth	4c. County Dore	of Death chest 9. Birthpl Count	ace (State or Foreign	
Director show	10	214-22-9921 sual Residence of Decedent to a. State 10b. County MD Dorch	ester	97	Dec			Dec. 11	, 1910	yland  Od. Inside City Limits  1X Yes 2 \( \) No			
a or 28a-f st		10e. Street and Number 520 Glenburn Avenue				10f. Zip (	2161	g. Citizen of W	/hat Count	ry?			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any fulury or other traumatic event, the Medical Examiner must be notified at once.	2	Marital Status     Never Married 2  Marri     Mwidowed 4  Divorced	12. Was Decede Armed Force ed 1 Tyes 2 If Yes, Give Year or Date	es? ⊠No		Vas Decede f Yes, speci	ent of Hispanic Or fy Cuban, Mexica No Specify:		ify Yes or No- ican, etc.)		e - America k, White, e wh:		
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To the Hospital or Attending Physician: The law requires that the death certifully 24 hours after death.  Within 24 hours after death.  Completely filled in by the funeral director, page 2 should be detached for use a Medical Certification. To Be Completed by Dhysician Medical Certification.	27	27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work?  1 Natural 5 Pending investigation  4 Could not be determined 28a. Date of Injury 28b. Time of Injury M 28c. Injury at Work?  1 Yes 2 No  28d. Describe how in 1 Yes 2 No  28d. Describe how in 1 Yes 2 No  28d. Describe how in 1 Yes 2 No  28d. Describe how in 1 Yes 2 No								reet and Numbe	and Number or Rural Route Number,		
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To th Withir Comp	29									Date signed (Month, Day, Year) - 4 - 0 \$			
Ц		D. Name and address of person of NOMAR TIDAN	wy 503	BYR	N 57		MRIDGE	£ 1	40 2	1613			
State	3	1. Date filed (Month, Day, Year)	32. Peg	istrar's Signa	ature	-							

Registrar
DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Albert M. Demao DP epman 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deatl Medial Center 8. Date of Birth (Month, Day, Y) Feb. 29, 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min. Year 87 176-09-6168 1920 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16206 Atlantis Dr. 20716 USA 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1∑Yes 2 No If Yes, Give Year or Dates: 42-45 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) VP Sales Manager Liquor Wholesalers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michele Demao Adeline Cristofano 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Violet F. Demao/Wife 16206 Atlantis Dr. Bowie, MD 20716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 2/8/2008 Silver Spring, MD of Funeral Service. 22. Name and Address of Facility M01442 Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy perform 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1X Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death 1 M Natural 2 Accident Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

**Physician** /Medical Examiner

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To the Hospital or Attending

P.O. Box 68760,

Division or Vital Records,

**Physician** 

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Director

Funeral

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**Funeral** 

Director

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item 27 is marked other than "naturai", or items 23a or other traumatic event, the Medical Examiner must be a

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permit. Pages 1 and 2 Department of Health a important; if item 27 is any Injury or other trat once.

Examiner

burial-trans Physician/Medical the use as j detached signed by I þ Completed Be 2 Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown

> 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

> > 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

him person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

3 ☐ Suicide

4 Homicide

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5 Pending investigation

6 Could not be

2008

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and	completely	ल ।	(Check only 2 Medical	Examiner: On the b	asis of exami	nation and/or	invest	igation, in m	y opinio	on, death	occurred	at the time					200(0)
	To Cl	com	P L	29b. Signature and title of c	and man	ner stated.					nse numb				29d. Date	signed	(Month,	Day, Year)
4			2	29b. Signature and title of C	601	0				0.0	C.M.E.				Februa	ry 2, 2	2008	
				my		-												
			3	30. Name and address of po	erson who completed	cause of dea	ath (Item 23a)	)		ine -	NAID O	24204						
				Ling Li, MD Ass	sistant Medical I	Examiner	111 Pei	nn St	treet, Balt	imbre	#, IVID 2	21201						
		0.	ate		rearb 2000	32. Registrar's	Signatur		brank.	,								
		ગ	ate	31. Date filed (Month, Day,)	1 2 2008	MARKEN	V /	A										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day FEBRUARY **Physician** Florence 5 - 30 PM 2008 Davis /Medical 4e. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Lanham Ductors Community Prince HOSPITAL Georges If Under 1 Year If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months 1 □ M 2 K F 176-09-8981 Director 1916 Parnassus, PA 31, Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits items 23a or 28a-f show ner must be notified at 1 XIYes 2 □ No Director Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3614 Maroon Lane Funeral U.S.A. 20715 death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. the Medical Examiner 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🖾 No Specify \$ Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene.

Is marked other than 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Charles A. Reimer Helen Garland traumatic ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 George S. Davis, Jr. - Son 3614 Maroon Lane, Bowie, MD 20715 Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 7 Department of Important: If its any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 2/5/2008 Brentwood, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Ave. Constance Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, and the cause in the cause of the cause (Disease or injury that initiated events resulting in death) Last Due to for as a conse wence of Examiner that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 DER/Outpatient 3 DOA Certification: To this funeral 27. Magner of Death 28a. Date of Injury (Month, Day Year) e Hospital or Attending P 24 hours after death. e Funeral Director: After t 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my calculated and place. 29a. Certifier Medical completely (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year)

State Registrar

DHMH 17 Rev 1/2001

8118 Good Luck Road Lanham, Merylan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signat

teather 31. Date filed (Month, Day, Year FFR 0 4 2008

**FEB 0 4** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 04:30 A M Esther Elizabeth Davis February 8. /Medical 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Memorial Hospital Havre de Grace Harkord If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Month, Day, Year) JUNE 15, 1926 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F Months Pennsulvania 209-14-4501 81 Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 ☐ Yes 2 📈 No Director Maryland Harkord Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 522 Robin Hood Road 21078 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 10 No ff Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No White Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pagas 1 and 2 should be filed within Dapartmant of Haalth and Mantal Hygiana. Important: If item 27 Ie marked other than "any Injury or other traumatic event, the Max any Injury or other traumatic event, the Max any Dince. Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Vicari Florence Brogan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dorothy Blevins (Daughter) 522 Robin Hood Road, Havre de Grace, Maryland 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State I Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Mem. Gardens | 2/11/2008 | Aberdeen, Maryland 22. Name and Address of Facility Zellman Funeral Home, P.A. 21. Signature of Funeral Service Licenses 123 S. Washington St. Havre de Grace, MD 21078 28a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INTRAVENTRICULAR HEMMORRHAGE **Physician** I HR. /Medical Due to (or as a consequence of) Examiner Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of). Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pertension 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of fnjury 28c. fnjury at Work? Medical Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifie Medicina 29c. License number 29d. Date signed (Month, Day, Year) D66136 Hosp Tehs

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r than "natural", or items 23a or 28a-f ebov the Medical Examiner must be notified at

Maryland 21215-0036

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> 31. Date filed (Month, Day, Year) FEB 16 Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAVrede GRACE, MO. 21078

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend Item 23a per dr., 8876,02/19/08dhb Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year **Physician** Month 6:15 A M ELIZABETH SNYDER DAVIS February 2008 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 138 Constitution Road Pylesville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 1 F Yrs Director 2/18/1924 Maryland 219-18-0272 83 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show rthan "natural", or Items 23a or 28a-f shov Ite Modical Experiment ust be notified at MD Harford Pylesville 1 ☐ Yes 2 💢 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 138 Constitution Road 21132 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gladys Merryman John Wilbur Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5998 Camel Back Lane, Columbia, MD 21045 Linda Wiley/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fawn Grove Cemetery 2/8/2008 Fawn Grove, PA 21. Signature of Funeral Service Lice 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 17314 Bart1. Editione disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) alshamero Physician wear /Medical Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 4 □ Pregnant at time of death 5 Other (specify) the detached Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 10 5 Residence 6 Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After Certification: 1 Matural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 - Homicide Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD MD 010783 E 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fawn Grove Pa Janne R. Olson MD UC Webb hane 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar courte.

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 8 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jan• 30°, 20°0°8 Evelyn Darner Eagle 1:35A M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Braddock Hgts. Vindobona Nursing Home Frederick 8. Date of Birth (Month, Day, Year) 1916 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 □ XF 91 Director 219-12-0804 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ä a or 28a-f sh MD Frederick Middletown 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Linden Blvd. 21769 USA ns 23a must b Funeral ural", or items 2 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ White 3 X Widowed 4 □ Divorced "natural", t c .... th and Mental Hygo... 27 is marked other than "natura "...matic event, the Medical E) Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>homemaker</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event Be Alonza Koogle Darner Zella Mae Gross ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Prospect St., Middletown, MD 21769 Mark Darner (Nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 2 Cremation 3 Removal from State Reformed cemetery 2/2/2008 Middletown, MD 5 Other (Specify) ature Funera Service Donald B. Thompson Funeral Home 31 E. main St., Middletown, MD Đ 21769 hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Part1. Enler the disease, or complica shock, or heart failure. List only one Immediate Cause (Final TRIAL months MIBRILLATION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): DISEASE Examiner TEX 2 worths CORONARU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit be executed Due to (or as a consequence of): Box 68760. physician Physician/Medical the attending IF FEMALE for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ fibrosis Imorar 2 No 3 Probably 4 Unknown 1 Tyes cate has been signage 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1□ Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA P this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James L. Koessler was 300 S. Church St. Middletown ames L. Koessler wo

State Registrar 31. Date filed (Month, Day, Year)

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edical Exami	ner		David Elkins		4) 6: ÷		Month February 8,	2008	0715 hrs
		4a. Facility Name (if not institution, give s	· ·		Annapolis	or Location of Deat	:n	4c. County of Death Anne Arundel	,
Funeral		5. Social Security Number 6. Sex	10 Green Holly D		If Under 1 Y		s. 8. Date of Birth	(MM/DD/YYYY) 9. Bir	thplace (State or
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after death with the Maryland al", or items 23a or 28a-f she iter must be notified at once	<b>Funeral Director</b>	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces?			Hispanic Origin? ( S ban, Mexican, Puert		14. Race - Amer White, etc.	ican Indian, Biack,
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ID 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Tris marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once.	o Be	Frank Elki 19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Si		rley Holt	greve oer, City or Town, State	e. Zip Code)
y, MD 21215-0036 and 2 should be filed within 7 tealth and Mental Hygiene. Item 27 is marked other than traumatic event, the Medica		Victoria Simmons H	lkins/Wife	1210	Green I	Holly Dri	ve. Annar	olis, MD	21409
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salti rmit. epartn nports jury c	21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor							lor Funera	1 Home, Inc.
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Physician /Medical	Physician  23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Atherosclerotic Cardiovascular Disease Complicated by								
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8760, ifficate be ng physicist the buri	-	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregr		etal death	3 Ectopic pregr	nancv	23d. Date of deliver Month	y Day Year
Box 68 c death certifi the attending ed for use as	icia	past 12 months?	4 Pregnant at time of dea	- L	ther (Specify)				
Bone dea	Physician	1 Yes 2 No 9 Unknown	9 Unknown				Too Bill	1	
of Vital Records, P.O. Box 68: ing Physician: The law requires that the death certificate that secutificate has been signed by the attending luneral director, page 2 should be detached for use as it.	by F	Part II. Other significant conditions of	ontributing to death but not re	sulting in the	underlying caus	se given in Part I.		2 No. 3 Pro	bably 4 V Unknown
dS, I			<del></del>	-			24a. Was a		utopsy findings available
Corc law re has be	Completed						autops perforr	y prior to	completion of cause of
Red The ficate	S						1 <b>✓</b> Yes 2		es 2 No
ital sician s certi	Be	25. Was case referred to medical examiner?	spital: 1 Inpatient 2	ER/Outpatien		Other Nurs		Residence 6 🗸 Othe	ar: Scana
of V g Phy:	1°	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of		Injury at Work?		ow injury occurred	1. Occine
Division of Vital Records, plial or Attending Physician: The law requirents after death.  eral Director: After this certificate has been similed in by the funeral director, page 2 should the	tion	1 Natural 5 Pending		Fnd 7:05	ia   1	Yes 2 X No	Unk		
ViSi or Att fter de Directe	ifica	2 Accident Investigation 3 Suicide 6 X Could not be				ce building, etc.	28f. Location (S		ural Route Number, City
Division ospital or Attend hours after death ineral Director:	Certification:	4 Homicide determined	(Specify) Unk				or Town, St 1210 Gree	n Holly Dr.Ar	napolis.MD
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,	dical		To the best of my knowledgen the basis of examination ar						
To the to comp	Medi	29b. Signature and title of pertiffer	nd manner stated.	id/or investiga		ense number	rat the time, date a	29d. Date signed (Mo	
		KI				C.M.E.		February 9, 200	
		30. Name and address of person who cor		23a)				, -, -,	
H 13.					treet, Baltin	nore, MD 2120	1		
		31. Date filed (Month, Day, Year)	32. Restrar's Signatu	re H	hand .		,		
Regist	irar	FEB 1 4 20	Jud Juden	15 /					

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MORRIS FITTS **FEBRUARY** 2008 10:40 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 4020 HENSON OAKS DRIVE LANDOVER HILLS PRINCE GEORGE'S 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** Months Days Hours 421-38-1732 73 Director MAY 29 1934 ALABAMA Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notifled at 10d. Inside City Limits Director 1 XYes 2 No MD PRINCE GEORGE'S LANDOVER HILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4020 HENSON OAKS DRIVE 20784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 Mo ARMY If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. AFRICAN 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐XNo Specify þ 3 Widowed 4 X Divorced AMERICAN Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)
4 YRS REGISTERED PHARMACIST PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be THOMAS S. FITTS MAMIE HIGHTOWER ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 item 27 is PETER FITTS/SON 7413 QUAIL RIDGE LANE BOWIE, MARYLAND 20720 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Important: If ite any Injury or or Pages 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GATE OF HEAVEN 2/7/2008 SILVER SPRING, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Head Neck Metastatic Canler 11 months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the death certificate be executed and bunal-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? 1☐ Yes 2☐ No Month Year 4☐Pregnant at time of death Day 5 ☐ Other (specify) detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed' 1□ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 5068 6 215 /08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GURDEEP S. CHHABRA M.D. 6510 KENIWORTH AVENUE SUITE 2800 RIVERDALE, MARYLAND 20737 31. Date filed (Month, Day, Year) 32. Registrar's Signa State FEB 0 6 2008

DHMH 17 Rev 1/2001

Registrar

			For Stete Registrer	State of I	Maryland	/ Depa		of He	ealth a				_	04797
		-	1. Decedent's Name (First, Middle,	( act)			lilicale	OIL	/eaiii		2. Date of Dea	Reg. No.		3. Time of Death
	Physicia	an		Forlizzi							Month	Day	Year	
	/Medic		4a. Facility Name (If not institution,		or)		4h City 7	Four or	Location o		Pebruar	*	2008 inty of Death	7:15 p. <sup>M</sup>
	Examin	er					4b. City, i						orche	
	<b>.</b>	1	Chesapeake W		Age (In yrs. las	t birthday)	II Under		ridge If Under 2		8. Date of Birt	n		
200	Funeral Director		178–16–6359	1 □ M 2 <b>½</b> F	86	Yrs.	Months	Days	Hours	Min.	(Month, Da)	r, Year)	Pon	nplace (State or Foreign untry) nsylvania
100	v		Usual Residence of Decedent								10v. /	1741	1 (11	IID y I Valida
	ylan		10a. State 10b. County		10c. City, 1	Town or Lo	cation							10d. Inside City Limits
	Ma Ma	cto	MD Dorch	ester			Ca	mbri	.dge					1X Yes 2 ☐ No
)	or 28	Director	10e. Street and Number		_		10f. Zip	Code				10g. Citizen		untry?
	23a		525 Glenburn	Avenue					21	613		Ţ	JSA	
	r des	Funeral	11. Marital Status	12. Was Decede Armed Force		13.	Was Decede	ent of His	panic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	14. [	Race - Amer Black, White	
36	or It	y Fu	1 Never Married 2 Marne	If Yes, Give			1 ☐ Yes 2		Specify:				ecify: W	hite
Ö	hour tural	d by	3 Widowed 4 Divorced	Year or Date		10- D	44-11-	10				405 Kind a	I Duringen	-4
7	"na"	Completed	15. Decedent's (Specify only highest	grade completed)		(Give	dent's Usual kind of worl DO NOT use	k done di e retired)	tion uring most	t of working	ng	160. Kind 0	l Business/l	ndustry
7	withi than	mc	Elementary/Secondary (0-12)	College (1-4	or 5+)		homen					owr	n home	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23s or 28s-f show event, the Medical Examinating and avent, the Medical Examinating and and a continuous control or security.		17. Father's Name (First, Middle, La	ist)						r's Name	(First, Middle,	Maiden Sun	name)	
an	d be ental ked c	To Be	William Harbo	14					Gr	ace	unkno	พา		
2	should ind Men ind marke	-	19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street a			Route Numbe		wn, State, Z	ip Code)
	and 2 ealth a n 27 is		Christopher M. O	'Donnell	p.r.	304	Laure	el St	., E	astor	n, MD	21601		
Baltimore,	t Heal		20a. Method of Disposition		20b. Plac		sition (Nam				ate	20c. Location	on - City or T	Town, State
Ę	Pages nent of int: If It		1   Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spe							2/12	2/08	Harri	isburg	, PA
量	_ E # 3									_	neral Home P.A.		•	
ä	Depermited Depermited Important Irreportant	1 Diki PE								mbridge		21613		
8			23a. Part 1. Enter the disease, or co	omplications that cau	sed the death.					•				Approximate
П	Physician		shock, or heart failure. List or Immediate Cause (Final	ny one cause on each	n iine.	hat	11104	100	11.0		11-03	. 0		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or	nic o	nce of):	acri	70	1001	90	11000			LUYCAS
2,	Examiner			hue	perter	151	2n							
		je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a conseque									
	cuted	Examiner	triat initiated events	C										
oʻ	te be executed ysiclen and e burial-transit		resulting in death) Last	Due to (or	as a conseque	nce ol):								
3760,	a % a	ical		d										
68	The law requires that the death certificate ale has been signed by the attending physicage 2 should be detached for use as the bases.	Physiclan/Med	IF FEMALE:									1	<u> </u>	
ô	th ce	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1⊟Live birth	me of pregnanc 1 2 ☐ Fetal de		Ectopic pre	egnancy				23d.	Date of deli	very Day Year
	the al	sici	1 Ves 2 No	4□Pregnan 9□Unknow	t at time of deat n	th 5[	Other (spe	ecify)					WORL	Day Todi
Vital Records, P.O. Box	d by	P	Part II. Other significant condition	= contribution to door	h hut got societi				a ia Dani I		220 Did to	banca usa i	antehuta ta	the cause of death?
Ś	w requires that been signed I should be det	Completed by	dementia	s contributing to deat	ar but not result	пдины	riderlying ca	iusa giva	II III Falti.	•				obably 4 Unknown
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ec	has the	npi									24a. Was autop	sv .	prior to d	topsy lindings available completion of cause of
F	: The	ပ္ပ	1,000								1 Yes	med? 2 No	death?	2□ No
<u> </u>	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	Hospital:				Othe	_ /		(Check only o	-		
ō	Physician: r this certifice ral director, p	. To	1 Yes 2 No 27. Manney of Death	1 🗀 Inp		NOutpatier 8b. Time o	nt 3□ DO	Α	4 Unive		ne 5 Resid			cify)
Division of	ding After fune	ion	1 Matural 5 ☐ Pending		Day Year)	Injury	M	Bc. Injury Work	ai ? ′es 2 □ i		8d. Describe t	iow injury oc	Curred	
2		lica	3 ☐ Suicide 6 ☐ Could no	t be 390 Place of	Injury - At hom	e farm str			03 2		Paf Location (5	Street and Ni	umber or Ru	ıral Route Number,
2	after Olre	Certification:	4  Homicide determin	building	etc. (Specify)	J, 1211111 311	oot, lactory,	, 011100			City or Tov			
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying	Physicien: To the be	st of my knowle	edge, deat	h occurred a	at the tim	e, date an	d place, a	and due to the	cause(s) and	d manner as	stated.
	1 24 to	Medicai	(Check only 2 Medical Ex	eminer: On the basi and manner	s of examination	n and/or in	vestigation,	in my op	inion, deal	th occurre	ed at the time,	date and pla	ce, and due	to the cause(s)
	withir To th	Me	29b. Signature and title ot certifier				29c.	License	number			29d. Date si	gred (Month	h, Day, Year)
			Maan	con we	J			400.	599	73		2/	5/0	8
	K			no completed cause (	of death (Item 2	За) (Туре,	Print)	, (	~	,	, ,	* * *		
			Patricia Jo	hnson	100	Bra	mble	2	Ca	mbr	idgl	MU		
9	Sta		31. Date liled (Month Day Year)	32. R	strar's Signatui	re Le	1 0	B.a						
	Registr	100		~ LUUO A			" A. in 190 1	6						

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2, 2008 **Physician** 9:31 P M February Giorgio Fiorucci /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Jan 15, 19 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Days Hours Italy 1 XM 2 ☐ F 74 Director 205-40-7295 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show notified at 1 Yes 2 No Director Montgomery Village MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number must be 20886 USA 10114 Little Pond Place Funeral . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. other traumatic event, the Medical Examiner 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bank 12 Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event Be Mario Fiorucci Clelia Antoniolli ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20886 MB 10114 Little Pond Place Montgomery Village, Bertha A. Fiorucci/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory: 02/05/08 Beltsville, MD 21. Signature of Juneral Service License Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HEART CONLESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 mpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 3□ DOA 2 ER/Outpatient 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Accident Injury within 24 hours after deau.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Ew, MD 00057124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (A) a2 CENTER DR. POCKU, 1/E. MD 20850 9901 Modical Troung 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 **FEB 0 5** Registrar

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Year 2:28 aM Irmgard Hartmann Fuchs February 01 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖾 F Yrs. Director 81 March 13, Germany 578-42-1852 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "naturel", or items 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Montgomery Silver Spring 10e, Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with it. Dapartment of Health and Mentai Hygiene. Important: if Item 27 is marked other than "naturel", or Items 23s or 20 and 10 page. 10f. Zip Code 10g. Citizen of What Country? 12669 English Orchard Court 20906 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. 3 XWidowed 4 Divorced Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Accountant Retail 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame, ို Unascertainable Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter R. Fuchs - Son 10617 Vale Road, Oakton, Virginia 22124 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 02/10/2008 Brentwood, Maryland 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licenses 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1 The the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic Obstructive Pulmonary Disease Days /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Congestive Heart Failure Days Due to (or as a consequence of): Examine Sit To the Hospital or Attending Physician: The law requires that the death certificate be executed Pneumonia Days and burial-trar Due to (or as a consequence of). Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Day 4 Pregnant at time of death 5 Other (specify) ed by the detached o Records, P. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď cate has been signated by page 2 should b Atrial Fibrillation, Hypertension, Diabetes, Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Peripheral Vascular Disease autopsy performed? 2□ No Division of Vital 1 Yes 2 No 1 ☐ Yes director 25. Was case referred to medical Be 26. Place of Death Check only one Hospital: 1 ⊠ Inpatient 2 □ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 Yes 2 No 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Directompletaly filled in by 4 Homicide 1⊠ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) elm, My 10/ February 1, 2008

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Aruradha Arun, M.D., 10301 Georgia Avenue, #209, Silver Spring, Maryland 20902 32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Amend #3 per PHYS 02-06-08 CNM Certificate of Death 04800 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** February Mildred Green 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Sept. 26, 1928 Maryland Director 216-22-7843 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland | Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 1 7106 Sundays Lane 21702 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ White 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Remittance Clerk Nat. Geographic Pages 1 and 2 should be filed vent of Health and Mental Hygie int: If Item 27 is marked other to 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Albert Eyler Mildred Leona Cockrell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Debora J. Green / Daughter 290 Pinoak Drive, Frederick, Maryland 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cem. 2/7/08 Frederick, Maryland 4 ☐ Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) massive **Physician** Gastnic Ulcer /Medicai Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 No 1□ Yes I or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Injury Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0064910 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 400 West 7th Street, Frederick, Maryland 21701 PRATIMA PANDEY

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

6 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Elaine 28,2008 Griffith January 6:45 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Baltimore Towson If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1 □ M 2 🗓 F Hours 220-38-0914 70 05/22/1938 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1XYes 2□No Maryland Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8003 Croom Road 20772 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Federal Government Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carter Howard Simmons Hazel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 0 4 3 19a. Informant's Name/Relationship (Type. Print) Catherine Davis/Daughter 7846 Rockburn Dr. Ellicott City, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 1/5/08 Clinton, Maryland Resurrection of F negal Su vice Lins 22. Name and Address of Facility Adams Funeral Home PA 191 20605 Aquasco Rd. Aquasco, Maryland20608 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): ert. cula IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? ∕es 2 ☑ No 25. Was case referred to medical examiner?

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

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Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural" or items any injury or other traumatic event, the Medical Examiner mi

1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. em 27 is marked other than "natural", or iter

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Funeral

Be Completed by

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law requires that the death certificate be executed

burial-transit for use ed by the a 24 hours after death.

e Funeral Director: After this certificate has been si letely filled in by the funeral director, page 2 should Certification: To

Physician/Medical Be Completed by

Examiner

9 Unknown

1 ☐ Yes 2 ☐ No

27. Manner of Death

1 ☑ Natural

2 Accident

3 ☐ Suicide

4 Homicide

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 🔲 Inpatient 2 ER/Outpatient 3 DOA

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated.

30. Name and address of person who completed cause of death The h 23a) (Type, Print)

harles St. Balts. Ind 21208

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Bunc 31. Date filed (Month, Day, Year)

5 ☐ Pending investigation

6 ☐ Could not be

FEB 05 2008

State Registrar

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within 2

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY 4 2008 7:26 A M GAUSE LYDIA 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1201 MERGANSER COURT PRINCE GEORGE'S UPPER MARLBORO If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Year 1 □ M 2 😿 F Months 242-20-3003 NORTH CAROLINA 92 NOV 4 1915 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits PRINCE GEORGE'S UPPER MARLBORO 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20774 USA 1201 MERGANSER COURT 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specia LACK 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 8th HOME MAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) OLLIE FRINK THOMAS REAVES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA A. GAUSE/DAUGHTER 1201 MERGANSER COURT UPPER MARLBORO, MARYLAND 20774 20c. Location - City or Town, State OLINA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 Other (Specify) PLEASANT VIEW CEME: 2/10/2008 SUNSET BEACH, NORTH 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE Due to (or as a consequence of): ATHEROSCLEROTIC HEART DISEASE Due to (or as a consequence of) DEMENTIA Due to (or as a consequence of):

**Physician** /Medical Examiner

certificate be executed

Division or Vital Records, P.O. Box 68760

or Attending

Hospital

**Physician** 

/Medical

Examiner

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**Funeral** 

Director

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death

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Pages 1 Important: If It any Injury or c

Baltimore, Maryland 21215-0036

must be notified at

Examiner

Director

Funeral

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Completed

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Examiner Physician/Medical

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Certification:

Medical

the burial-tran and physician use as t the signed by has certificate After this within 24 hours after death.

To the Funeral Director; Af Succeeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

4☐Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

Month Day

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death? 1 🔲 Yes X No 3 Probably 4 Unknown 24a. Was an

autopsy performe

1∐ Yes 2⊠ No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes **X**☐ No

Year

Hospital: 1 Inpatient 28a. Date of Injury

2 ER/Outpatient 3 DOA 28b. Time of (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

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Other: 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only one) of certifier 29b. Signature and title

5 ☐ Pending investigation

6 Could not be determined

25. Was case referred to medical examiner?

1 ☐ Yes 2 ⊋ No

27. Manner of Death

1 X Natural

2 Accident

4 Homicide

3 ☐ Suicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

FEBRUARY 5, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PETER SCHISSLER M.D. 7500 GREENWAY CENTER DRIVE # 430 GREENBELT, MARYLAND 20770

Registra

31. Date filed (Month, Day, Year) FEB 0 6 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** eb. /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester General Birthplace (State or Foreign Country) **Funeral** 100 M 2□F Days Months Delaware Director NOV. 17. 1962 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director aston Talbox 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code USA 26 Funeral N WOOD 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. s 1 and 2 should be filed within 7 if Health and Mental Hygiene. item 27 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Dishwasher Inn 10 permit. Pages 1 and 2 should be filed. Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gross Henry ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Court Easton, MD, 216 of 20c. Location - City or Town, State Darrin Williams 61-Glenwood 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Richards Men 08 Men Park | 22. Name and Address of Facility Easton, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

HENRY FUNERAL Home, P. A.

510 Washington St. Cambridge

23a. Pat. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Impossible Company of the path of the leath of MD.21613 Immediate Cause (Final disease or condition resulting in death) Cirrhosia **Physician** /Medical Due to (or as a consequence of): Examiner nen mani-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

this certificate

Be

Medical

25. Was case referred to medical examiner?

1 Tes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 ☐ Homicide

28c. Injury at Work?

24a. Was an 2 400

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

MA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

1 ☐ Yes 2 ☐ No

30. Name and address of person who comp eted cause of death (Item 23a) (Type, Print)

Hospital:

5 Pending investigation

6 ☐ Could not be

determined

28a. Date of Injury (Month, Day Year)

503 BYRN NOMAN 7HANW 31. Date filed (Month,

State Registrar

			1- For State OF IV Registrar	Co	ertificate of			ene 2008	04804
r	Physici		1. Decedent's Name (First, Middle, Last)  Joan N. Greene				2. Date of Death Month January	31, 2008	3. Time of Death  1:10 AM
	/Medic Examin		4a. Facility Name (If not institution, give street and number	)	4b. City, Town, o	r Location of Death		4c. County of Death	1
			Shady Grove Adventist Hosp 5. Social Security Number 6. Sex 7. 7. A		Rockvi		R Date of Right	Montgome	
	Funeral Director		214-48-8446 1□M 2ÅF	ge (In yrs. last birthda 89 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month Day, April 2)	Year) 1918 Ma	place (State or Foreign Intry) SSSachusetts
	aryland show dat	J.	Usual Residence of Decedent  10a. State 10b. County	10с. City, Town or					10d. Inside City Limits 1 ☐ Yes 2X No
	the M. 28a-f notifie	Director	Maryland Montgomery  10e. Street and Number	Roc	kville 10f. Zip Code		10	g. Citizen of What Co	
	3a or	ij	299 Hurley Avenue			350		United St	•
	death	Funeral	11. Marital Status 12. Was Deceden Armed Forces	t Ever in U.S. 13	3. Was Decedent of H if Yes, specify Cubi		pecify Yes or No-	14. Race - Amer Black, White	ican Indian,
215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Me. Iteal Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X If Yes, Give Year or Dates	] No	1 ☐ Yes 2 ☐XNo		o rilican, etc.)		nite
2	72 hc	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dec (Gi	cedent's Usual Occup ve kind of work done b. DO NOT use retired	nation during most of wor	king 1	6b. Kind of Business/I	ndustry
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<u>Ian</u>	T = 0 4	To B	John Anderson			Carey	(1	unknown)	
Maryland	2 sh and ls m		19a. Informant's Name/Relationship (Type. Print)					City or Town, State, Z	ip Code)
	1 and Health em 27 ther tr		Cary W. Greene, Son		Ipswich I			0 20814 20c. Location - City or "	Town State
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Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	and the same of th				l Home, P.A sville, MD	
			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each						20705 Approximate Interval Between
	Physician	e i	Immediate Cause (Final				, ,		Interval Between Onset and Death
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X Q Q	attending for use	Physician/N	23b. Was decedent pregnant in the past 12 months?	2 Fetai death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of deli Month	very Day Year
j	the d by the ached	nysic	1 ☐ Yes 2 X No 4 ☐ Pregnant 9 ☐ Unknown 9 ☐ Unknown	at time of death	Sill Other (speciny)				
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o o	require	ted				-	1 □ Ye	s 2∐No 3∐Pro	obably 4XIUnknown
Hecords,	aw s b	Completed					24a. Was an autopsy	24b. Were au prior to death?	topsy findings available completion of cause of
VITAL			OF Was soon referred to modical				perform 1 Yes 2		2 <b>X</b> No
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0	ding Phys .r After this funeral di		27. Manner of Death  1 Natural 5 □ Pending  28a. Date of In (Month, D	jury 28b. Time	of 28c. Inju		28d. Describe ho		,
<u>S</u>	tendii leath. tor: A the fu	catic	2 Accident investigation			Yes 2 □ No			
UIVISION	pital or Attendous after deatheral Director:	Certification:	determined 200. Flace of the	njury - At home, farm, etc. <i>(Specify)</i>	street, factory, office		City or Town	eet and Number or Ru , State)	iral Houte Number,
	Hospita 24 hours Funeral stely fille	Medical C	29a. Certifier (Check only one)  1 XCertifying Physician: To the besis and manner and manner series.	of examination and/or	eath occurred at the ti	me, date and place opinion, death occu	and due to the ca rred at the time, da	nuse(s) and manner as ate and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	P	29c. Licens	1 5 1 1	0 29	d. Date signed (Monti	n, Day, Year)
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	*		30. Name and address of person who completed cause of		•			20050	
	1 CI	•		1 Medical trar's Signature	*	ive, Kock	Ville, M	20850	
	Sta Registr		FEB 0 4 2008	we IF A	reeles				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jant 31, Da 2008 Year Physician Evelyn **GRFFN** 4:00 A.M /Medical Facility Name (If not institution, give street and number)
Laurel Regional Hospital 4c. County of Death Prince Georges 4b. City, Town, or Location of Death **Examiner** If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 X F Jan. 26, 1921 Philadelphia, PA 165-14-3823 87 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ms 23a or 28a-f shor r must be notified a 1 ☐ Yes 2 X No MD Montgomery Silver Spring Director 10e. Street and Number 3148 Gracefield Rd., # 503 10f. Zip Code 20904 10g. Citizen of What Country? Completed by Funeral death ural", or Items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No White Specify 3 ☐ Widowed 4 ☐ Divorced "natural" the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) tt of Health and Mental Hygiene.

If Item 27 Is marked other than or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Office Manager City Public Works 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Finn Joseph Gershenhorn ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Green / son 3422 Briars Rd., Brookeville, MD 20833 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Mt. Sharon Cemetery 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb.1, 2008 Philadelphia, PA Department of Important: If any Injury or 21. Signature of Funer Servic Lens 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that cadded the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Fat Embolism **Physician** /Medical Due to (or as a consequence of): Examiner Osteorosis Sequentially list conditions, if any, leading to immediate cause. Enter the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the use as t attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be d Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypertension Diabetes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No Cardiac Arrhythmia To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28b Time of 28a Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation nours after death.

neral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours at To the Funeral C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 2008 D44156 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 31. Date filed (Month, Day, Year) Registrar's Signature State FEB 04 2008 Registrar

,			For	State	of Marylan					1ental Hy	/gien	ie	m I	~ ~ ~
			1 - State Registrar			Cei	rtificate d	of Deatl	h		Reg. N	102 U U 8	UL	1800
н	Physici	an	Decedent's Name (First, Middle							Date of De     Month		ay Year	3. Tim	e of Death
Α	/Medic		<u> </u>	reshoff G						Januar	_	1, 2008		40p <sup>™</sup>
)	Examin	er	4a. Facility Name (If not institution				4b. City, Tow				4	lc. County of Dea	ith	
		急	Washington Adv 5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday)	If Under 1 Yo	oma Pa		8. Date of Bi	rth	Montgo		ate or Foreign
	Funeral Director	;	570-54-9060	1 ☐ M 2 🖾 F	68	Van	Months Da			(Month, Da	ay, Yea	(r) C	ountry)	_
	April		Usual Residence of Decedent							March	10,	1939 0	111101	III.a
	yland now at		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							e City Limits
	e Mar a-f sl	ctor	Maryland	Montgome	ery	Sil	ver Spr	ing					1 🗆 '	∕es 2 No
	iff the	Director	10e. Street and Number				10f. Zip Cod	le			10g. C	Citizen of What C	ountry?	
	ath w		104 Denver Roa					20910				USA		
	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status	Armed F		.S. 13.	Was Decedent If Yes, specify (	of Hispanic C Cuban, Mexic	Origin? (Specan, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Am Black, Whi		1,
36	s afte	by F	1 ☐ Never Married 2 ☐ Marrian	If Yes. G	2 <b>∑M</b> No ive ⊃ates:		1 □ Yes 2√€	No Specif	fy:			Specify:	_	
8	hour Itural	ed		t's Education	Julios.	16a. Dece	dent's Usual Od	cupation			16b.	Whit		
Ç.	in 72 n "na nedic	Completed		st grade completed)		ı (Give	kind of work do	one durina m	ost of work	ing	1			
212	y with giene r tha the N	E O	Elementary/Secondary (0-12)	College	(1-4or 5+) 5+		Profes	sor			Ed	ucation		
פ	e filec al Hyg othe vent,	BeC	17. Father's Name (First, Middle,	Last)				18. Mot	ther's Name	e (First, Middle	e, Maide	en Surname)		
<u>a</u>		70	James Brown H	erreshoff				Ed	dith M	Meyer				
Maryland 21215-0036	~ ~ ~ ~	·	19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailir	ng Address (Sti	eet and Num	nber or Run	al Route Numb	ber, City	or Town, State,	Zip Code)	
	and; ealth m 27 her tr	r.	hristine C. Gor	don/Daugh		4	214 Cro	sswick	Tur			MD 20715		
0	00		20a. Method of Disposition 1 ☐ Burial 2X ③ Cremation	3 □Removal from	1 /	Place of Dispo cemetery, crei	sition (Name o natory or other	place)	Feb	3,	20c.	Location - City o	r Town, State	9
Baltimore,	t. Pag tment tant; I		4 □ Donation 5 □ Other (S		Me	-	itan Cr		,	2008		lexandri	-	rginia
Ra	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service	Licensee		F 5	rancis 00 Univ	J. Col ersity	llins Blvd	Funera d, W, S	l H	ome Inc. er Sprin	ıg, MD	20901
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the deat each line.	h. Do not ent	er the mode of	dying, such a	as cardiac	or respiratory a	arrest,		Approxi Interval	mate Between
1	Physician		Immediate Cause (Final disease or condition	а	CARD	iom	YOPAT	HV					Onset a	ind Death
家.	/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):		,						
	LXammer	<u>.</u>	Sequentially list conditions,	b Saturbin	CHEM for as a consec	OTHE	RAPY						-	
	ted isit	nine	Sequentially list conditions, if any, learning to initial date cause. Enter Underlying Cause (Disease or injury that initiated events	SAR SAR			ALICE							
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c	BREA (or as a conseq		ANCE	X						
8/60	e be e	dical E		d										
200	ificate g physi as the b	edic		0.										
Ř	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		itcome pf pregna birth 2 ☐ Feta		Testonio pro en	an out			- 4	23d. Date of de	elivery	
	death e atte	sicia	in the past 12 months? 1 ☐ Yes 2 No	4□Preg	nant at time of c		Ectopic pregn Other (specif					Month	Day	Year
J O	at the de by the a	hys	9 ☐ Unknown	9∐Unkr	iown									
	es thai igned b	by F	Part II. Other significant conditi	ons contributing to o	death but not res	ulting in the u	nderlying cause	given in Par	rt I.			o use contribute		
ecords,	w require been signature should to	ted								1	Yes	2 <b>∑</b> No 3∏ F	robably 4	Unknown
ပ္ပ	> 9 10	ple								24a. Was	psy	prior to	completion	ngs available of cause of
ř	The law cate has page 2 s	Completed								perf 1⊟ Yes	ormed?	? death? No 1 ☐ Ye		
VIta	sician: Th certificate rector, pag	Be	25. Was case referred to medica examiner?	Hospital: 6				26. Pla	ace of Deat	h (Check only	one)			
0	this al dii	٦.	1 Yes 2 No 27. Manner of Death	28a. Date		ER/Outpatier 28b. Time o		4 🗆 1	Nursing Ho	ome 5 Res		6 ☐Other (Sp	ecify)	
	ding F h. After funer	ion	1 Natural 5 ☐ Pendir	ig (Moi	nth, Day Year)	Injury	1	Injury at Work? 1 ∐ Yes 2[	ΠNo	Zod. Describe	11044 111	jury occurred		
DIVISION	ten leat tor the	ficat	3 Suicide 6 Could	not be 28e Plac	e of injury - At h	ome, farm, str				28f. Location	(Street	and Number or F	Rural Route	Number,
	al or / after   Dire d in b	Certification:	4 ☐ Homicide determ	build	ling, etc. (Specia	fy)				City or To	own, Sta	ate)		
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director; After completely filled in by the fune	Medical (		ng Physician: To th Examiner: On the I										se(s)
	o the ithin of the o the omple	Mec	29b. Signature and title of certifie		Tiller stated.		29c. Lic	ense numbe	er		29d. [	Date signed (Mor	nth, Day, Yea	ar)
)	F > F 0		1	1/	) , , ,	nn	D	278	37		FF	BRUDDI	101	2008
	20		30. Name and address of person	who completed cau	ise of death (Iter	n 23a) (Tvpe.			- (			BRUARY	1 1	2000
	4		LOUIS & LARCA			E AUE		TAKON	na Pi	ARK, M	ARY	LAND,	2091	Z
	Sta		31. Date filed (Month, Day, Year)		egistrar's Signa									
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arvey Gribble		State of Maryland / Department of 1- For State Certificate of		giene Reg.	No. 2008	0480
Physicia	an/	Decedent's Name (First, Middle,Last)		Date of Death     Month D	av Year	3. Time of Death 1612 hrs
ledical Exami	ner	narvey binwood dribbie	o. City, Town, or Location of Death	February 4,	2008 4c. County of Death	10121115
		Southern Maryland Hospital	Clinton		Prince George'	S
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth(	MM/DD/YYYY) 9. Birth Foreign	
Director		228-72-2510 1 <sub>X</sub> M 2 F 59 Yrs.	Months Days Hours Min.	APR.24		
any		Usual Residence of Decedent  10a. State 10b. County 10c. City. Town or Location	n			10d. Inside City Limits
*		VA Westmoreland Colonial				1 X Yes 2 No
Aaryland 28a-f show 1 at once	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Count	ry?
nith the Maryland 23a or 28a-f show	Öire	13 Lossing Avenue	22443		II. S. A	
with ms 23	eral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	Decedent of Hispanic Origin? ( Spess, specify Cuban, Mexican, Puerto I		14. Race - Americ White, etc.	an Indian, Black,
death w	Funeral	1 Yes 2 No		Alcan, etc.)		
hours after "natural", Examiner	ģ	15 Decodert's Education (Presify only highest grade completed)   160 Decodert's	Yes 2 X No specify: s Usual Occupation (Give kind of w	ork done 1	Specify: Whi  6b. Kind of Business/In	
2 hour	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	st of working life. DO NOT use retire		SS. Family St. December 7	330.17
036 ithin 7 ne.	ng d	12 Delvie	ery Driver		AERO Ene	rav
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica			18.Mother's Name	(First, Middle, Ma		- 9 2
121 Id be f fental narked event,	o Be		France Address (Street and Number or R	S J. Do		Zin Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sht injury or other traumatic event, the Medical Examiner must be notified at once	ř	1	•			1.0
e, N I and Health item			Rutherford B	Date	20c. Location - City or 1	Town, State
HOP Pages ent of nt: If			Ch.Ceme. 12,	ruary	Warsaw, V	irginia
Baltimore, permit. Pages I a Department of He Important: If ite		21. Signature of Funeral Service Licensee 22. No.	ame and Address of Facility	mond Fi	ınl Servi	Ce P A
		Tongs 1820 July 563	ame and Address of Facility Ray 35 Washington	Ave.,La	Plata,M	D 20646
Physician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter th failure. List only one cause on each line.		respiratory arres	t, snock, or neart	Approximate Interval Between Onset and Death
caminer		Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):	ease			Death
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	aminer	if any, leading to immediate Due to (or as a consequence of):				
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60, nte be executed hysician and e burial - transit	dical E		·	<del></del>		
60, ate be e hysician e burial	ledic	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
6876 certifical oding ph	an/N	23b. Was decedent pregnant in the past 12 months?	al death 3 Ectopic pregna	ncy		ay Year
Box 6876 he death certificate the attending phy hed for use as the b	Physician/Me	1 Yes 2 No 9 Unknown g Unknown	er (Specify)			
D. B. t the de by the	Phy	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
P.O. es that the signed by be detac	d by			1 Yes	2 No 3 Prob	ably 4 Unknown
rds, requir been s	ete			24a. Was an		opsy findings available ompletion of cause of
tal Records, P.O. cian: The law requires that th certificate has been signed by ector, page 2 should be detach	ompleted			perform	ned? death?	
Vital Rec ysician: The his certificate	Be C	25. Was case referred to medical	26.Place of Death (Check of	only one)		
of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should i	To B	1 Yes 2 No Inpatient 2 V ER/Outpatient			esidence 6 Other	:
n of ding Ph		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Ir	njury 28c. Injury at Work?	28d. Describe ho	w injury occurred	
Division tal or Attendii rs after death al Director: A	cati	2 Accident Investigation 28e. Place of Injury - At home, farm, stree		28f. Location (St	reet and Number or Ru	ral Route Number, City
Divisi pital or Att ours after de	Certification:	3 Suicide 6 Could not be determined (Specify)	, ,,	or Town, Sta		
Hospi 24 hou Funer tely fil			ed at the time, date and place, and	due to the cause	(s) and manner as state	ed.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	ledical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.				
	Ž	29b. Signature and title of certifier	29c. License number		29d. Date signed (Moi February 5, 2008	
U id		my wimp	O.C.M.E.		T GUIUAIY 3, 2000	
711		Name and address of person who completed cause of death (Item 23a)     Ling Li, MD	t, Baltimore, MD 21201			
	tate	31. Date filed (Month, Day Year) 32. Registrar's Signature	89			
Regis	trar	FEB 1 6 2008 Reserve A 1990				

State of Maryland / Department of Health and Mental Hygiene [] [] [ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FEBRUARY 8 2008 WAYNE OLIVER GOLDSMITH 3:45PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FT.WASHINGTON REHAB. CENTER PRINCE GEORGE'S FT. WASHINGTON If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months **1** M 2 □ F Yrs Director 214-52-7011 6.1 MAY 16,1946 MARYLAND Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ? Is marked other then "natural", or items 23a or 28e-f show traumatic event, the Modical Examinal must be notified at 1 ☐ Yes 2 🙀 No Directo MD. CHARLES NEWBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11910 FRERE'S PLACE U. S. A.

14. Race - American Indian,
Black, White, etc. 20664 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after al Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐ No Specify: δ Specify: 3 ☐ Widowed 4 ☑ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 3 CARPENTER SELF-EMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fil ment of Health and Mental H tant: If Item 27 Is marked ott Be ARCHIE T. GOLDSMITH RENA L. OLIVER 19a. Informant's Name/Relationship (Type, Print) (SON) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARVEY W. GOLDSMITH MEADOWVIEW DRIVE NEWBURG, MD 20664

Date 20c. Location - City or Town, State 9821 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) FEBRUARY 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or once. TRINITY MEM.GRDNS, 15, 2008 WALDORF, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD20646 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onsetjand Death Do not enter the mode of dying, such as cardiac or respiratory arrest, or complications that caused the death Immediate Cause (Final disease or condition resulting in death) Priysician the. /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physicien and the burial-transit Due to (or as a co P.O. Box 68760. Physician/Medical as the attending IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No detached for Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 2 No 1 Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed/ 1 Yes 2 No 1 🗌 Yes 2 12 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 V No 1 🔲 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. May er of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After the Hospitel or Attending 1 V Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours atter deat To the Funeret Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 020808 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAXMI BERWA, 7700 OLD BRANCH AVE., CLINTON, M.D. MD 20735 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 1 6 2008

DHMH 17 Rev 1/2001

		•	for State Registrar	State of Maryland /		rtment of H			giene	18 04809
r	0		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death
П	Physici /Medic		Charlotte Marie	Hicks				Februa	,	008 02:15pm M
)	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Dea	th	4c. County of	
			Chesapeake Manor	Assisted Living	<u> </u>	Princes			Somers	
	Funeral		5. Social Security Number 6. Sec	IM NOTE		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Day	h y, Ye <i>ar)</i>	Birthplace (State or Foreign Country)
	Director		579-20-8366	82	Yrs.			02-11-	1925 W	Mashington D.C.
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Loc	ation				10d. Inside City Limits
	Mary if sho	jo	MD Somerset	Princ		<b>1</b>				1 ☐ Yes 2 No
	28a	rec	10e. Street and Number	. TITHE	ess .	10f. Zip Code			10g. Citizen of W	hat Country?
	3a ou	Funeral Director	27070 Annie Hyland	Road		218.	53		USA	
	death	nerg	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. W			Specify Yes or No- no Rican, etc.)	14. Race	- American Indian,
ပ္	after or ite	F	1 Never Married 2 Married	1 Yes 2 No		Tes, specify Cubal	Specify:	nto i noan, oto.)	Specify:	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or llems 23a or 28a-f show than "Medical Examinat must be notified at	d by	3 Widowed 4 □ Divorced	Year or Dates:						White
2	natu	Completed	15. Decedent's Edu (Specify only highest grade	cation 16: e completed)	(Give k	ent's Usual Occupa ind of work done a O NOT use retired	luring most of wo	orking	16b. Kind of Bus	siness/Industry
12	withir noe. then	d m	Elementary/Secondary (0-12)	College (1-4or 5+)		,	,		C C D T	la lambama
D D	Hygie ther ther		12 17. Father's Name (First, Middle, Last)	none T	етер	none Oper		me (First, Middle,		elephone
an	d be ental ced o	To Be	Walter Raymond Sk	inner			Charlot	te Irene	Pavne	
Maryland	shoul nd M marl	-	19a. Informant's Name/Relationship (Ty		b. Mailing	Address (Street a		lura/ Route Numbe		State, Zip Code)
ž	alth a 27 is		Calvin R. Hicks/S	on 2	7070	Annie H	yland Ro	ad, Prin	cess Ann	ne, MD 21853
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at ance.		20a. Method of Disposition	comet	of Dispos	ition (Name of atory or other place	e)	Date	20c. Location -	City or Town, State
Ë	Page not: If int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ P  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-			04-2008	Salisbur	ry, MD
att	mit. ports y inju	1	21. Eignature of Funeral Service Liby s	ee <u> </u>	22.	Name and Addres	s of Facility	0		
m	89 5 5 8		VIMEN Z (VIA	M DM00295	111	673 Some	erset Av	e., Prin	cess Anr	ne, MD 21853
			shock, or heart failure. List only or	cations that caused the death. Do	not ente	r the mode of dying	g, such as cardia	ac or respiratory ar	rrest,	Approximate Interval Between
И	Physician		mmediate Cause (Final disease or condition	Due to (or as a consequence		alsha	mers	discon	e	Onset and Death
	/Medical Examiner	2	resulting in death)	Due to (or as a consequence	e of):					1
	Lxammer	_	Sequentially list conditions,	)	0					
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Each of John ing. Cause (Disease or injury	Due to (or as a consequence	9 OI).					
	cate be executed physician and s the burial-transit	xan		Due to (or as a consequence	e of):					
8760,	siciar buria									
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Box	nding use a	Z/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy					23d. Date	e of delivery
	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant at time of death		Ectopic pregnancy Other <i>(specify)</i>			Mor	nth Day Year
0.0	tt the by th	hys	9 🗆 Unknown	9□ Unknown						
	Se US	by F	Part II. Other significant conditions con	tributing to death but not resulting	in the un	derlying cause give	en in Part I.			ibute to the cause of death?
ord	w require been si should I	ted						1 🗆 \	Yes 2.XXNo	3 Probably 4 Unknown
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<u> </u>		Con						1 Yes	med? d	eath? ☐ Yes 2☐ No
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	la anitat.		04		eath (Check only o	one)	sted Lilling
of	Physician: r this certific ral director,	은	1 192 5 140	lospital: 1   Inpatient 2   ER/C			4   Nursing	Home 5 Resid	dence 6 other	
D U	ding h. After funer	lon	27. Manner of Death  1 ★ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Time of Injury	28c. Injury Work	rat ⟨? Yes 2 □ No	200. 00501001	10W IIIIJUTY OCCUTT	ь
isi	or Attending after death. Director: After in by the fune	ical	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home,	farm stre			28f. Location (	Street and Numbe	er or Rural Route Number,
Division	after Direction	Certification:	4 Homicide determined	building, etc. (Specify)		-1,,		City or Tov	vn, State)	
	24 hours 24 hours 8 Funeral etely filled			sician: To the best of my knowled						
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medical Exemi	ner: On the basis of examination a and manner stated.	and/or inv	estigation, in my op	oinion, death occ	curred at the time,	date and place, a	and due to the cause(s)
	To the within 2. To the complet	Me	29b. Signature and tyle of certifier	1/1		29c. License	number	7 /	29d. Date signed	(Month, Day, Year)
)			1/ MA	1-1-		-DO	0599-	5/	2/4	12008
				empleted cause of death (Item 23a	) (Type, F	Print)	MAL VA	100	115	01853
2	EB		DR. Charles	R-HOLLANCO	10,3	30434	INH, VE	ANOW !	& tru	ncesthing IM
	Sta Registr		FEB 0 6 2	32. Redistrar's Signature	k ,	hall .				
	ricgisti	Ç.	, 25 0 0							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death Physician Belle 1, 1:20 AM M Harris February 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hartley Hall Nursing Home Pocomoke City Worcester If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 10/19/1924 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Yrs. Director 226-22-5077 83 Virginia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 X Yes 2 No MD Worcester Pocomoke City 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with tent of Health and Mertal Hygiene.
Intent of Health and Mertal Hygiene.
Intent of Y is marked other than "natural", or items 23a or 2 and 17 is marked other than "natural", or other traumatic event, the Medical Examiner must be n 333 Winter Quarters Drive 21851 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Bookkeeper Hardware Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willie McCov Nannie Alexander 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William K. Harris/son 6481 Cricket Hill Road, Westover, MD 21871 Department of Health Important: If item 27 any injury or other troone, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State First Baptist Cemetery 2/4/2008 Pocomoke City, MD 4 ☐ Donation 5 ☐ Other (Specify) Hinman Funeral Home 21. Signature of Funeral Service Licensee KANGI 1.M0029511673 Somerset Ave., Princess Anne, MD 21853 2da. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ARDIO MYO PATHY /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ Yo 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) the a 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P funeral 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 5 Pending investigation 1 Matural after death.

Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MI 00062172 214/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POCEMORE GIY MO 21851 R JATYAL, M.D 1604 MARKET ST 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 6 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene- UU Certificate of Death

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ear	3. Time of Death
8	5:15 ₽ <sup>M</sup>
Death	
igto	n
. Birthpl	ace (State or Foreign try)
ran	će
10	d. Inside City Limits
	1 □XYes 2 □ No
at Coun	try?
America White, e	an Indian, etc.

1 - For State Registrer

1. Decedent's Name (First, Middle, Last)

. 7		8	1. Decedent's Name (First, Middle, Las	t)		2	Date of Death		3. Time of Death
	Physic /Medi		Paulette ReJar	ne Houghton		l I	Month February	3, 2008	5:15 ₽ <sup>M</sup>
	Exami		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, o	or Location of Death		4c. County of Dea	
		E .	337 N. Potomac S		Hager			Washingt	
	Funeral Director		5. Social Security Number 6. Sec. 216–46–2595	TM 20XE	birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Ye		thplace (State or Foreign ountry)
Н	*4		Usual Residence of Decedent	81			/08/1926	Fra	ince
	nyland how		10a. State 10b. County	10c. City, To	wn or Location		<del></del>		10d. Inside City Limits
	e Ma	cto	MD Washingt	ton Hage	rstown				1 □XYes 2 □ No
	ith th	Dire	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	ountry?
	ath w	ra	337 N. Potomac St		21740			JSA	
	ter de Kem	Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cub	lispanic Origin? (Specif an, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Ame Black, Whit	
920	hours after death with the Maryland urat; or teme 23a or 28a-1 show at Exerticer must be notified at	þ	3X Widowed 4 □ Divorced	1  Yes 2 <b>X</b> No If Yes, Give Year or Dates:	1 ☐ Yes 2 No	Specify:		Specify: LT	nite
0	be filed within 72 hours after death with the Marylar Ital Hygiene.  Id other than "natural", or iteme 23a or 28a-f show other than "natural", or iteme 23a or 28a-f show event, the Madical Exemirer must be notified at	Completed	15. Decedent's Edi	ucation 16	a. Decedent's Usual Occup	pation	16b	. Kind of Business	
2	within 900.	npie	(Specify only highest grad	College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	during most of working d)			•
2	filed w Hygier Ither th		12		Clerk			Retail Cl	othing
and	tal H	Be	17. Father's Name (First, Middle, Last)	1		18. Mother's Name (F	irst, Middle, Maid	den Sumame)	
Ž	should be ind Mental i marked umatic ev	2	Joseph (unk) Gard		N. A. III.	Lea (unk)			
Z	and 2 s salth an n 27 is i		William R. Suzor		b. Mailing Address (Street				Zip Code)
Baltimore, Maryland 21215-0036	Heart term		20a. Method of Disposition	20b. Place	26 Lafayette of Disposition (Name of	Date		Location - City or	Town, State
Ë	Pages nent of int: If it		1 Ma Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		ery, crematory or other place Lawn Memorial I		_		
alti	글 문원를 .		21. Signature of Funeral Service Licens			ss of Facility Gera		gerstown, Innich Fu	ກeral Home
m	Depa Impo any l		163n-K	7 S		tomac St. H			
			23a. Part1. Enter the disease, or complishock, or heart failure. List only o	lications that caused the death. Do	not enter the mode of dyin	g, such as cardiac or re	espiratory arrest,		Approximate Interval Between
E.a.	Physician		Immediate Cause (Final disease or condition	_ Acute Respirat	tory Failure				Onset and Death 24 hrs
	/Medical Examiner		resulting in death)	Due to (or as a consequence	of):				24 111.5
	LAdillilei	L	Sequentially list conditions,	Chronic Obstru		Disease			10 Yrs.
	ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):				
	al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence	of):				
760	se be (		L.	1					
Box 68760,	eath certificate be executed ettending physicien and for use as the burial-transit	clan/Medical							
ŏ	th cer tendir r use	an/N	-oo. Trao account program	3c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death	h 3 Ectopic pregnancy			23d. Date of deli	very
	73 0 73		in the past 12 months?	4 Pregnant at time of death	5 Other (specify)			Month	Day Year
<u>т</u> О	The law requires that the de ite has been signed by the c page 2 should be detached	Completed by Phys	9 Unknown						· · · · · · · · · · · · · · · · · · ·
Š,	signe signe d be o	þ	Part II. Other significant conditions con Atrial Fibrilati		in the underlying cause give	en in Part I.			the cause of death?
Ö	w require been significant	etec		.011			1 L Yes	2UX(No 3∐Pro	obably 4 Unknown
Vital Records,	has has	E G					24a. Was an autopsy	prior to d	topsy findings available completion of cause of
<u></u>	ician: The I certificete ha rector, page		OF Management				performed? 1 ☐ Yes 2 🛣		2 No
5	Physician: this certific ral director.	<b>a</b>	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	lospital:	utnationt 30 DOA Othe	26. Place of Death (C			
Ö	9 Phys	n: To	27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/Ot 28a. Date of Injury 28b.	dipatient 3 DOA	4   Nursing Home	5 Residence Describe how in		afy)
DIVISION	nding l ath. r: After e funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Time of 28c. Injury Work	(? Yes 2 □No	2000.100 1.011 1.1	jary cocumed	
<u>s</u>	al or Attending F s after death. I Director: After d in by the funer	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa	arm, street, factory, office	28f.	Location (Street	and Number or Ru	ral Route Number,
	spital or cours after narel Dir filled in						City or Town, Sta		
	등 수 필 우	Medical	29a. Certifier 1 X Certifying Phys	sicien: To the best of my knowledge ner: On the basis of examination are and manner stated	e, death occurred at the time nd/or investigation, in my op	e, date and place, and pinion, death occurred a	due to the cause	(s) and manner as	stated.
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	and manner stated.	29c. License				
)	⊢ 3 <del>-</del> 8 - 4		Alam & M re	(m (b).	D238			ate signed (Month 104/2008	, Day, Tear/
			30. Name and address of person who co	/				., 2000	
3F	1-20		Mary E. Money, MD			21740			
	Sta		31. Date filed (Month, Day, Year)	32. Raistrar's Signature	1 4.				
	Registra	ar	FEB 0 8 20	UB March St.					

JH-5

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

FARID

FEB 07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

0060396

02/06/08

21740

MD

			For State Registrar	State of M	1aryland		artment of H		and Mental Hyg	giene 0 0 8	04813
			1. Decedent's Name (First, Middle,	Last)					2. Date of Dea		3. Time of Death
	Physici		Ella Louise	Hoffman					Februar	v 5 200	
	/Medic Examin		4a. Facility Name (If not institution, g	give street and number	r)		4b. City, Town, or	Location of		4c. County of E	Death
			Broadmore Assi	isted Livir	าต		Hage	rstow	n	Was	hington
	Funeral			S. Sex 7. A	ge (in yrs. la:	st birthday)	If Under 1 Year Months Days	If Under Hours		9	Birthplace (State or Foreign Country)
	Director		218-38-0888	1 □ M <b>3(TX</b> F	67	Yrs.	Months Days	Hours	Dec.30,	1940	Maryland
_	pu 🖈		Usual Residence of Decedent  10a. State 10b. County		100 City	Town or Lo	eating				10d. Inside City Limits
	shov	<u>-</u>			Toc. City,						1X Yes 2 □ No
	Ba-f	Director		ington		V	/illiamspo	ort		to- Cities of 14th	
	with t	吉	10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	Country
	s 23	sral	10614 Honeyfie	eld Road 12. Was Deceden	t Guer in II C	10.1		21795		14 Pace -	USA American Indian,
	iten de	Funeral	11. Marital Status 1 □ Never Married 2 □ Married	Amed Forces	7	. 13.	f Yes, specify Cuba	n, Mexicar	gin? (Specify Yes or No- n, Puerto Rican, etc.)	Black, V	Vhite, etc.
38	irs af	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates			1□Yes 2⊠ No	Specify:		Specify:	White
ŏ	filed within 72 hours after death with the Maryland Hygiene. Wher then "naturel", or Items 23a or 28a-f show wit, the Modical Examinational Landillist at	ed	15. Decedent's		1	16a. Dece	dent's Usual Occupa	ation		16b. Kind of Busin	
715	7 nin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or	(54)	(Give life.	kind of work done of DO NOT use retired	du <i>ring</i> mos 1)	t of working		
213	d with	mo:	12	Conege (1-40)	34)		Laborer			Ribbon Ma	nufacturer
Maryland 21215-0036	othe	Be C	17. Father's Name (First, Middle, La	ıst)				18. Mothe	er's Name (First, Middle,	Maiden Sumame)	
lar	Alenta Alenta rked tic e	ToE	Simon Thomas	Stouffer				Mar	y Rosalie	Domer	
ary	shore		19a. Informant's Name/Relationship	o (Type, Print)		19b. Mailir	ng Address (Street a	and Numbe	er or Rural Route Numbe	r, City or Town, Sta	te, Zip Code)
Σ	s 1 and 2. of Health ar item 27 is		Thomas Stouffer	- Brother			Brookside		ace Hagers	town, Mar	yland 21742
re	of He item		20a. Method of Disposition		20b. Pla	ice of Dispo	sition (Name of matory or other plac	(e)	Date	20c. Location - Cit	or Town, State
Ĕ	Page Nent of nt: If		1 Burial 2 Cremation 3 4 Domation 5 Other (Spe		9			4	eb.8.2008	Williamsn	ort, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel; or Items 23a or 28a-f show any injury or other treumatic event, It is Marical Examinating in inside in Milled at ODGs.		21. Six ature of Funeral Supply Li	×1688	10.00				Home, P.A.		21795
m	permi Depa Impo any ii	ď.	1-10	XI.	-				,	illiamspo	rt, Maryland
			23a. Part Enter the disease, or co shock, or heart failure. List or	omplications that caus	ed the death.				cardiac or respiratory ar		Approximate Interval Between
	Physician :		Immediate Cause (Final	lly one cause on each	0-04	Nan	suejal	1 -	Miner		Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or a	is a conseque		o we your		ousur		
П	Examiner				11	10-	11 Selle	10(2	l		
	1 - 0	er	Sequentially list conditions, if any leading to immediate	b Due to (or a	a comeque	эпсе of):	.0 .20		•		
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ć	exec in an	Exa	resulting in death) Last	Due to (or a	is a conseque	ence of):					
8760,	The law requires that the death certificate be executed ste has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical		d							
9	ificat g phy as th	edi									
Вох	eath certific attending p for use as f	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			7ri			23d. Date o	,
	death e atte d for	icla	in the past 12 months? 1 □ Yes 2 □ No	1□Live birth 4□Pregnant	at time of dea		Ectopic pregnancy Other (specify)	·		Month	Day Year
0	that the de led by the a detached	hys	9 🗆 Unknown	9□ Unknown							
٣,	es tha igned be det	by P	Part II. Other significant condition	s contributing to death	but not result	ting in the u	nderlying cause give	en in Part I	. 23e. Did to	bacco use contribu	te to the cause of death?
Records,	quire in sig uld b	t be							101	′es 2□No 3[	Probably 4. Onknown
00	w requir s been si should	ete							24a. Was		e autopsy findings available
æ	he lav e has age 2	Completed							autop	rmed? dea	r to completion of cause of th? Yes 2□ No
Vital		a	25. Was case referred to medical					26 Place	1 ☐ Yes a of Death (Check only o	- /	
	ysicien: The lar is certificate has director, page 2	o B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 □ Inpa	tient 2∏F	R/Outpatier	nt 3 DOA Othe	or	ursing Home 5 Resid		Specify)
Division of	Attending Physicien: r death. sctor: After this certific by the funeral director.	$\vdash$	27. Mann f Death	28a. Date of In	ijury 2	28b. Time o				now injury occurred	opouty,
On	nding I th. : After ; funer	it or	1 atural 5 Pending 2 Accident investiga	(Month, E	Day Year)	Injury		k? Yes 2 🔲	No		
/isi	I or Attending Ph after death. Director: After th I in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could no	ed 286. Place of I	njury - At hon	ne, farm, str	eet, factory, office		28f. Location (S	Street and Number	or Rural Route Number,
á	i di te	erti	4 Homicide	building,	etc. (Specify)				City or Tou	m, State)	
	spite								nd place, and due to the		
	To the Hospitel or within 24 hours after the Funerel Direct completely filled in the funerel birect completely filled in the funerel birect filled in the funerel filled in the	Medical	(Check only 2 Medical Ex	kaminer: On the basis and manners	of examination stated.	on and/or in	vestigation, in my or	pinion, dea	ath occurred at the time,	date and place, and	due to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier				29c. Licenso	e number		29d. Date signed (A	Nonth, Day, Year)
			hulen	11 1.	1 1	M	175	362	3	Chouse.	( ) WY
			30. Name d address of person wi	ho completed cause of	death (Item :	23a) (Type,	Print)		4		1 3 2000
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DHMH 17 Rev 1/2001

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		1- For State Registrar			Certi	ificate d	of Deatl	h		R	Reg. No.	6.01	0 0 9 0 1
Physicia	_	1. Decedent's Nam	e (First, Middle,Las	st)						Date of Dea     Month	ath Day	Year	3. Time of Death
Medical Exami	ner	Jor	ge Alber	to Hernan	dez				1	February			1804 hrs
7		4a. Facility Name (	if not institution, giv	e street and number	)		4b. City, T	Town, or Lo	cation of Death		1	County of Deat	n
•		NB CSX tra	cks near Ches	stnut Street cros	sing		Gaith	ersburg			I	lontgomery	
Funeral		5. Social Security	Number 6. S	ex 7. As	ge (In yrs. las	t bi <b>rt</b> hday)		er 1 Year	If Under 24Hrs.	8. Date of B	irth (MM/I	DD/YYYY) 9. Bir	thplace (State or
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	ŀ	none Usual Residence o			2- I					07-02	_170	1	
any		10a. State	10b. County		10c. City, T	own or Loc	ation						10d. Inside City Limits
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Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  If item 27 is marked other than "matural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once.		21. Signature of Fi	uneral Service Lice	nsee	C. 3	/ / 22			Facility 344				Da 00010
		wan	ca C,	plications that cause	10,00	Po not onto							DC 20010 .  Approximate Interval
Physician Medical			ne disease, or com nly one cause on e		o the death.	Do not ente	r the mode	or dying, so	Juli as caldiac c	respiratory a	irest, sin	ook, or near	Between Onset and
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760 cate to physical	ĭ.	IF FEMALE:		23c. If yes, outcome							23	3d. Date of delive	
68 ertifi iding	ian	23b. Was deceden past 12 month		1 Live birth	at time of dea		Fetal death		Ectopic pregna	ancy		Month	Day Year
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the d	Physician/Medi	Part II. Other sign	ificant conditions		ath but not re	sulting in th	e underlyin	ng cause giv	ren in Part I.	23e. Dio	tobacco	use contribute	to the cause of death?
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed extens. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transi	by			J		· ·				1 Y	es 2	✓ No 3 Pr	obably 4 Unknown
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Of ng Pl	n:	27. Manner of Dea	ath	28a. Date of Ir (Month, Day	njury (Year)	28b. Time	of Injury	28c. Injury		,		jury occurred	
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Division tal or Attendir rs after death. ral Director: A	ij	3 Suicide	6 Could no	28e Place of	Injury - At ho	me, farm, s	treet, factor	ry, office bu	ilding, etc.				Rural Route Number, City Thersburg, MD
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Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director, a completely filled in by the fi	Medical	one) 2 🗸	Medical Examine	er:On the basis of ex	amination ar	nd/or invest	igation, in m	ny opinion,	death occurred	at the time, da	ite and p	lace, and due to	tne cause(s)
F 3 F 8	Me	29b. Signature an	d title of certifier	/			29	9c. License	number		29d	. Date signed (A	fonth, Day, Year)
		(nu	de 4	A 00 n	10			O.C.N	1.E <i>.</i>		Fe	bruary 8, 20	08
26	1 15	30. Name and add	dress of person who	completed cause or	death (Item	23a)							
(K (L)	01 1	Carol Allar	· ·	ant Medical Exa			n Street,	, Baltimo	re, MD 2120	01			
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DHMH 17 Rev 1/2001 OCME 2006

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 12:50 p M Paul Peter Hanley /Medical 2008 February 3 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Rehab. and Nursing Center Montgomery

9. Birthplace (State or Foreign Country)

New York <u>Burtansville</u> 8. Date of Birth (Month, Day, Year) May 27, 1930 7. Age (In yrs. last birthday) Under 24 Hrs. Social Security Number 6. Sex **Funeral** Days 1 M 2□ F Director 097-22-8280 Usual Residence of Decedent Show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 1 □Yes 21 No Director Silver Spring 10f. Zip Code Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 206 Lexington Drive 20901 USA death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X☐ Yes 2☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white à 3 Widowed 4 Divorced Korea Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) d 2 should be filed with and Mental Hygier 7 is marked other the DC Firefighter Firefighting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Hanley Clara Benedict 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If item 27 is Jane M. Hanley/Wife 206 Lexington Drive, Silver Spring, MD 20901 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Feb. 8, Burial 2 Cremation 3 Removal from State ö permit. Page Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2008 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Carcinoma of Lung disease or condition resulting in death) 1 Year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events authorise devents Due to (or as a consequence of) Examine certificate be executed burial-transit attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 0 ned by the a 2 No 9☐Unknown 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 Yes 2 No 3 Probably 4XUnknown Bilateral Pneumonia, Parkinson's Disease page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate 2 X No 1∏ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: A Nursing Home 5 Residence 6 Other (Specify) Hospital: 2**X** No 1 Tes ပ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D24093 February 4, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 Gracefield Road, Silver Spring, MD 20904 Mark Parkhurst, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature FEB 05 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dav  $P^{M}$ Venus D. Harary 2, 2008 February 7:36 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5500 Friendship Blvd Apt. 2023 N. Chevy Chase Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 1 F Hours 579-42-6892 95 Director Dec. 22, 1912 Cairo, Egypt Usual Residence of Decedent within 72 hours after death with the Maryland f show 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at K Yes 2 No Director Maryland | Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5500 Friendship Blvd. Apt. 2023 N. 20815 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Issac Lisbona Clarie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Fralin / Attorney, Exec. 2200 Clarendon Blvd #1201 Arlington, Va. 22201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 Crematory Feb. 5, 08 Falls Church, Va. 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 4 Donation 5 Dother (Specify) National Crematory 21. Signature of Funeral Service Ligense 5130 Wisconsin Ave N.W. Washington D.C. 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Brest Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) death certificate be executed burial-transi Due to (or as a consequence of): Box 68760 attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🔀 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2X No 24a. Was an page 2 has certificate 1∏ Yes 2K No 25. Was case referred to medical examiner? 26. Place of Death Check onl one) Be Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No P After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Division To the Hospital or Attending 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death То the Funeral Director: сотрletely filled in by the 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mr D32033 2/4/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

egistrar's Signature

5530 Wisconsin Ave.

31. Date filed (Month, Day, Year) FEB 0 5 2008

Peter G. Hamm, MD

Chevy Chase, Md 20815

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) Mary Mae Hartley 2. Date of Death 3. Time of Death Feb 4 2008 0045 Ам 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Frederick Calvert Calvert Memorial Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | May | Ma 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1□M 2√F Maryland 212-07-7446 89 Usual Residence of Decedent I0c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Calvert Port Republic 1 ☐Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 4400 Broomes Island Road 20676 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married white 1 ☐ Yes 2 No 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PG Board of Education cafeteria manager unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nellie Sears Walter Jones Brown 19a. Informant's Name/Relationship (Type. Print) Beth Sandidge- goddaughter/ executor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1680 Ball Road Port Republic MD 20676 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Bel Air Memorial Gardens Feb 7 2008 Bel Air Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATOR INSUFFICIENCY Due to (or as a consequence of): BILATERAL PLEURAL EFFUSIONS WURTAUN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of) If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Day Year 9□Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an autopsy performed? 1□ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical Examiner

physician and s the burial-trans

attending p as

After this

o the Hospital or Attending Plantin 24 hours after death.
o the Funeral Director: After the ompletely filled in by the funeral

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

r 28a-f show notified at

Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medica Exa<u>miner must be r</u>

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 Is marked other than "natural", or ite

Baltimore, Maryland 21215-0036

Director

Funeral

þ

Completed

Examine Physician/Medical Completed by Be Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown

25. Was case referred to medical 1 Yes 2 No 1 Inpatient 2 ER/Outpatient

investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year) 5 Pending

3 DOA 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

27. Manner of Death

2 Accident

3 ☐ Suicide

4 Homicide

Natural Natural

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WD

and manner stated.

D0064961 WASGEMA DR

PRINCE FLEDGRICK

1971920H ROPD, 31. Date filed (Month, Day, Year) 32. Registrar's Signature

6 2008

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State

Medical

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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erbert Toda		1	For State Certificate of Death			J. No.				
Physi	icia		egistrar Decedent's Name (First, Middle,Last)		2. Date of Death Month February 1	Day Year	3. Time of Death 0025 hrs			
•I Exa	min		Herbert Todd Hobbs  la. Facility Name (if not institution, give street and number)  4b. City, 7	own, or Location of		, 2008 4c. County of Death				
			Prince George's Hospital Center  Chevi			Prince George	e's			
Funer	al	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace								
Directo			578-82-2233   1x M 2 F   30 Yrs.   Months Days Hours Min.   April 24,1977   Foreign Country Washington, D.							
any	d		Usual Residence of Decedent				10d. Inside City Limits			
*	-11	١	Maryland Prince Georges Capitol Heigh				1 X Yes 2 No			
Maryland 28a-f show	l at on	Director	10e. Street and Number		10	og. Citizen of What Cou United St				
h the l			4014 heath street	20743	in? ( Specify Yes or No-		ican Indian, Black,			
ath wit	st pe r	Funeral	1 Never Married 2 Married Armed Forces? If Yes, speci	fy Cuban, Mexican,	Puerto Rican, etc.)	White, etc.				
fter de: ", or i	er mu		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2	X No specify:		Specify:	ack			
ours af	the Medical Examiner	g p	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual during most of wo	Occupation (Give I	kind of work done use retired)	16b. Kind of Business	/Industry			
16 n 72 h nan "n	ical E	mpleted	Elementary/Secondary (0-12)	ok		Private				
-003 4 withi rgiene. ther th	e Med	S	17. Father's Name (First, Middle, Last)	18.Mother	's Name (First, Middle, I	Maiden Surname)				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	ent, th	Be	Tyrone Vincent Hobbs	Bar	ba <u>ra</u> Pugh					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho	or other traumatic event,	2				19a. nformant's Name/Relationship (Type, Print) 19b. Mailing Addres		eet S.E. Wa		
, MD and 2 sho ealth and em 27 is	raum	-	20a. Method of Disposition 20b. Place of Disposition (Na	me of cemetery,	Date Date	20c. Location - City o	r Town, State			
IOFE ges 1: pt of H	other		1 X Burial 2 Cremation 3 Removal from State crematory or other place Resurrection	n n	2/8/2008	Clinton,	Md.			
Baltimore, permit. Pages 1 an Department of Hea Important: If iter	injury or	1	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and	d Address of Facilit	y P A					
Der De	Ē	1	Alexander horo Pope / Forestville, Md. 20747							
, □hysicia 4 die			23a. Part I. Enter the disease, or complications to a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate interval Between Onset and Death							
∡àmin	_	İ	Immediate Cause (Final disease or condition resulting in death)  a. Multiple Gunshot Wounds  Due to (or as a consequence of):							
	Sequentially list conditions, b.									
							e-la			
· 19	nsit	Examine	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):							
execut	ial - tra									
UNPENDED  AMENDED  AMENDED  AMENDED  AMENDED  AMENDED  23d. Date of delivery  Amended by the second of pregnancy  Amended by the second of						•				
68 certifi	d.  UNPENDED  AMENDED  AMENDED  IF FEMALE: 230. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  Contributing in the underlying cause given in Part II.  23e. Did tobacco use contribute to the cause of the underlying cause given in Part II.						Day			
23b. Was decedent pregnant in the past 12 months?  Yes 2 No 9 Unknown  2 Fetal death 3 Ectopic pregnancy  North Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown  2 Other (Specify)  2 Other (Specify)  2 Other (Specify)  2 Other (Specify)  2 Other (Specify)  2 Other (Specify)  2 Other (Specify)  2 Other (Specify)  2 Other (Specify)  2 Other (Specify)						to the cause of death?				
P.O.	5 2	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying	ng cause given in P			robably 4 Unknown			
IS, P.C quires that	uld be	ted			autopsy findings available					
COCC law re	24a. Was an autopsy performed?  1 V Yes 2 No 1 V Yes  26 Place of Death (Check only one)									
of Vital Records, ng Physician: The law requin	director, page	To Be	25. Was case referred to medical	26.Place of Death	(Check only one)	2 10 1				
Vital hysteiar this cer	directo		O B	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3	DOA Other	Nursing Home 5		her:		
1 Of Jing Ph	funeral		27. Manner of Death  28a. Date of Injury  (Month Day Year)  233.7 hrs	28c. Injury at Wo	Subject sh	e how injury occurred ot				
Division tal or Attendi	<u> </u>	catic	Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factor		· .	(Street and Number or	Rural Route Number, City			
Divi	filled in by	Certification:	3 Suicide 6 Could not be determined (Specify) Sidewalk	State) ro Pike, Capitol Heig	ghts, MD					
						tated. the cause(s)				
To th	COM	Medical	and manner stated.	29c. License numbe		29d. Date signed (				
			('aroe La o Oan	O.C.M.E.		February 1, 20	800			
0/2			30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn Stree	t Baltimore M	D 21201					
177	-	tate		, Dalimore, W						
Re	ت gis		CCD N 7 2008' A.   Washington	-						

ORIGINAL

Baltimore, Maryland 21215-0036 Division or Vital Records, P.O. Box 68760,

Private   Temporal Control   Private   Priva			For State of Maryland  State of Maryland  Registrar		artment of He rtificate of D			giene 2 () () ()	8 04820
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23a. Part. Enter the disease, or donolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause on each file.  **METASTATIC BREAST CANCER**  **Due to (or as a consequence of):    Cause (Disease or influity in death)   Last	and Nama		19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ng Address (Street a	nd Number or Rui	al Route Numb	per, City or Town, State	, Zip Code)
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Physician Medical Examiner Secretary (1997)  23. Part I. Either the finances or Septical counter the mode of dying, such as cardiac or respiratory arrest, introduction and the service occurs on each line.  24. Part I. Cheer significant conditions and desired or condition resulting in death)  25. Part I. Cheer significant conditions are consequence of):  26. Due to (or as a consequence of):  27. Due to (or as a consequence of):  28. Due to (or as a consequence of):  29. Due to (or as	permi Depar Impon any ir		21. Signature of Funeral Service Licensee						
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Due to (or as a consequence of):	Physician		Immediate Cause (Final						Onset and Death
Due to (or as a consequence of):    Due to (or as a consequence of):			resulting in death)	ence of):					
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Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a consequence of):	ed sit	nine	if any, leading to immediate Due to (or as a consequicause. Enter Underlying Cause (Disease or injury	ence or):					
Section   Sect	by Series Intal Initiated events resulting in death) Last Due to (or as a consequence of):								
FFEMALE: 23c. It yes, outcome pf pregnancy   1   Live birth 2   Fetal death 3   Schotler (specify)   23d. Date of delivery   Month Day Year   1   Ves 2   No. 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Ves 2   No. 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Ves 2   No. 3   Probably 4   Unknown   24b. Was case referred to medical earlier of completion of cause of death?   1   Ves 2   No. 3   Probably 4   Unknown   25b. Was case referred to medical earlier of completion of cause of death?   1   Ves 2   No. 3   Probably 4   Unknown   25b. Was case referred to medical earlier of completion of cause of death?   1   Ves 2   No. 3   Probably 4   Unknown   25b. Was case referred to medical earlier of completion of cause of death?   1   Ves 2   No. 3   Probably 4   Unknown   25b. Was case referred to medical earlier of completion of cause of death?   1   Ves 2   No. 3   Probably 4   Unknown   25b. Was case referred to medical earlier of completion of cause of death?   1   Ves 2   No. 3   Probably 4   Unknown   25b. Was case referred to medical earlier of completion of cause of death?   1   Ves 2   No. 3   Probably 4   Unknown   25b. Was case referred to medical earlier of completion of cause of death?   1   Ves 2   No. 3   Probably 4   Unknown   25b. Was case referred to medical earlier of completion of cause of death?   1   Ves 2   No. 3   Probably 4   Unknown   25b. Was case referred to medical earlier of completion of cause of death?   1   Ves 2   No. 3   Probably 4   Unknown   25b. Was case referred to medical earlier of completion of cause of death?   1   Ves 2   No. 3   Probably 4   Unknown   25b. Was case referred to medical earlier of completion of cause of death?   1   Ves 2   No. 3   Probably 4   Unknown   25b. Was case referred to medical earlier of completion of cause of death?   1   Ves 2   No. 3   Probably 4   Unknown   25b. Was case referred to medical earlier of cause of Death   1   Ves 2   No. 3   Probably 4   Unknown   25b. Was case referred to medical earlier									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1   Yes   2XD No   3   Probably   4   Unknown	= _ 0	edic	u.						
25. Was case referred to medical examiner?  1	the death certy the attendin	ıysician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 ANo  23c. If yes, outcome pr pregnant 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3□					
25. Was case referred to medical examiner?  1	that ned by deta	y P	Part II. Other significant conditions contributing to death but not resu	Iting in the ur	nderlying cause give	n in Part I.	23e. Did	tobacco use contribute	to the cause of death?
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25. Was case referred to medical examiner?  1	The law re e has bee age 2 sho	omplet					auto perfe	ppsy prior t ormed? death	o completion of cause of ?
Matildatt. So M.D. 1221 MERCANTILE LANE LARGO, MARYLAND 20774	ian: rtifica		25. Was case referred to medical			26. Place of Deat		21	e3 2□ <b>3</b> Xº
Matildatt. So Lo D26250 02-06-2008  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  MALTIDA SO M.D. 1221 MERCANTILE LANE LARGO, MARYLAND 20774	nysic nis ce	2		ER/Outpatien	nt 3 □ DOA Othe	r: 4 Nursing Ho	ome 5 <b>X</b> Resi	idence 6 □Other (Sp	pecify)
Matildatt. So M.D. 1221 MERCANTILE LANE LARGO, MARYLAND 20774	ng Pl	.:uo	(Manual Davi Vana)				28d. Describe	how injury occurred	
Matildatt. So M.D. 1221 MERCANTILE LANE LARGO, MARYLAND 20774	tendi	cati	2 Accident investigation			′es 2 □ No	00/ 1	(0)	D -15 N
Matildatt. So M.D. 1221 MERCANTILE LANE LARGO, MARYLAND 20774	after o	ertifi	determined   200. Flace of Injury - At 1101	)	eet, ractory, office				Hurai Houle Number,
Matildatt. So M.D. 1221 MERCANTILE LANE LARGO, MARYLAND 20774	e Hospita 124 hours e Funera letely fille		(Check only 2 Medical Examiner: On the basis of examinat						
Matildatt. So M.D. 1221 MERCANTILE LANE LARGO, MARYLAND 20774	To th	Me	29b. Signature and title of certifier		29c. License	number		29d. Date signed (Mo	onth, Day, Year)
MALTIDA SO M.D. 1221 MERCANTILE LANE LARGO, MARYLAND 20774	(A)		Matildatt. So, N	ري		2625	0	02-6	16-2008
	20					MARYI.AN	D 2077	'4	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month /Medical 2000 4a. Facility Name (If not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner Crofton Convalescent Center Crofton Anne Arundel If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, ) July 13, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖸 F Maryland 1924 Director 212-20-1620 83 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐Yes 2 No Director MD Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1715 Leisure Way Funeral 21114 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status ə filed within 72 hours after dı ıl Hygiene. other than "natural", or item Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No à Specify: 3 ☐ Widowed 4 A Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important; if item 27 is marked other the any injury or other traumant. Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter C. Scheller Helen K. Deminas ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jane K. Heuer/Daughter 1715 Leisure Way Crofton, MD 21114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Crem. Alexandria, VA 2/4/2008 21. Signarde of Funeral Service M<sub>0</sub>1 442 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 23a. Part1. Enter the disease, shock, or heart failure. L complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Betw Onset and De Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Examiner requires that the death certificate be executed burial-tran Due to (or as a conseque Box 68760. physician Physician/Medical the attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 mont 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown by signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 2 No 3 Probably 4 Unknown 1 TYes Completed peen Were autopsy findings available prior to completion of cause of certificate has autopsy page performe death? 1 ☐ Yes Division or Vital 2 No 2□ No 25. Was case referred to refedical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Tes 2 No 2 ER/Outpatient 3 DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient After this 27. Manner Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending (Month, Day Year) 1 atural 5 Pending n 24 hours after used.....the Funeral Director: Af 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

FEB 0 5 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 12:00 PM Bobby L Harrison /Medical January 31, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Nursing Home Largo Prince George's If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 249-66-8389 1**X** M 2 □ F 67 McCormick, SC Yrs Director 4-7-1940 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Upper Marlboro 1 ☐ Yes 2 No Director Prince George's 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 6520 Dower House Road 20772 United States
O- | 14. Race - American Indian, Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2x ☐ No Specify Specify: 3√2 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Private 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charlie Harrison MillieTutt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angel Harrison (daughter) 6520 Dower House Rd. Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln\_Cemetery 2/8/2008 Brentwood, MD 21. Signature of Funeral Service Lice see 22. Name and Address of Facility Fort Lincoln Funeral Home B401 Bladensburg Road Brentwood, MD 20722 23a. Part1. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fails re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Conary Artery Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Diabetes, Hypertension, Cerebrovascular disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: AV Nursing Home 1 ☐ Yes 2 X No 2 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending investigation neral Director: A filled in by the fu death. 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Louis V. Kaufman, MD 12070 Old Line Centre Suite 207 Waldorf, MD 20602 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State FEB 0 5 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 0 4823 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 4:04 am Maribel F. Henschel Fe buary 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Boutimore None If Under 1 Year If Under 24 Hrs. Hours Min. B. Date of Birth (Month, Day, Jan 2, 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🖺 F 84 1924 Missouri 492 32 9607 Director Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10h. County 10d. Inside City Limits 1 ☐Yes 2 TXNo Director MD Baltimore Catonsville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 215 Maiden Choice Lane CC201 21228 United States Funeral death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 **X**No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be pe Hattie O. Kallenbach C. Ernest Fendorf Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 9898 Carrigan Drive Ellicott City, MD 21042 Ann H. Seed/Daughter Department of Heal Important: If item 2 any injury or other injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Ardent Crematory 2-4-2008 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. an (d Matin 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician severe metabolic 5 hours /Medical Due to (or as a consequence of) **Examiner** of non Hodikin cass Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-trar Due to (or as a consequence of) Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknow signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 4 Unknown 1 Tyes 2 No 3 Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed Yes 2 certificate 1∏ Yes Division or Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 Yes 2 No or Attend after death. filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral D Hospital X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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State Registrar EB 0 5 2008

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bothmore, MD 32. Registrar's Signature

P70966

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04824 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death umbia Howard Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours OM 2□F 163 28 6721 Sept 14,1935 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 TYes 2X No Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9911 Carillon Drive 21042 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Electrical Engineer Westinghouse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Hunter Minerva Pedrick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Madeleine E. Hunter/Wife 9911 Carillon Drive Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 2-7-2008 Crest Lawn Memorial Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Physician /Medical Examiner law requires that the death certificate be executed attending physician and for use as the burial-tran by the a

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

be

Examiner must

traumatic event, the Medical

Department of Health a Important: If item 27 is any injury or other tra

Director MD

Funeral

by

Completed

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Examiner Physician/Medical signed by t Certification: To Be Completed by nas certificate within 24 hours arter com.

To the Funeral Director: Aft

Division or Vital Records, P.O. Box 68760,

or Attending Physician:

Hospital

a)00

Medical

State

Registrar

29b. Signature and title of certifier

James 31. Date filed (Month, Day, Year)

30. Name and address of person who

FEB 0 5 2008

disease or condition resulting in death)	a Carollopvimonary Ar	west.	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):  Malamant Malamant  Due to (or as a consequence of):	- Dikea	ne -
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
	ntributing to death but not resulting in the underlying cause given in Part f.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
		24a. Was an autopsy performed? 1 Yes 2 ₩	
25. Was case referred to medical examiner?		ath (Check only one)	
1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H	lome 5 ☐ Residence	6 ☐Other (Specify)
27Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Work?  Injury M 28c. Injury at Work?  1 ☐ Yes 2 ☐ No	28d. Describe how inj	jury occurred
3 Suicide 6 Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	and Number or Rural Route Number, te)	
29a. Certifier ertifying Physical (Check only one)	sician: To the best of my knowledge, death occurred at the time, date and place ner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	e, and due to the cause urred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)

29c. License number

100 PK

29d. Date signed (Month. Dav. Year)

use of death (Item 23a) (Type, Print)

8835

gistrar's Signature

State of Maryland / Department of Health and Mental Hygiene [] [] 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 11:30 A M 3 JoAnn Rosalie Hughes /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Worcester Atlantic General Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 6/25/1936 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🛣 F Months MD 217-32-7771 71 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rel', or iteme 23a or 28e-f ehow Examiner must be notified at 1 ☐ Yes 2 No Director MD Worcester Ocean City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 319 Sunset Dr. Apt. 1 21842 USA death Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 X No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3X Widowed 4 ☐ Divorced naturel Depertment of Health and Mental Hygiene. Important: If Item 27 Ie marked other then "naturenty Injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Alexander J. Sullivan Ruth Nash 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 319 Sunset Dr., Apt 1, Ocean City, MD 21842 Joseph Hughes / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State 2/7/2008 Frankford, DE Cape Henlopen Crem. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 23a. Part I. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 108 William St., Berlin, MD 21811 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a conseque Examiner Sequentially list conditions. cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): 2/3/08 1/30 P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 4 □ Pregnant at time of death 5 Other (specify) ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Récords, þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No certificate has been si rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No of Vital 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Dete of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 2 Accident 5 Pending death. Director: / investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) ţ 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier BA filed (Month, Day, Year) State FEB 0 5 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Dav Year **Physician** Doris Ruth Hollern Α 11:30 2008 January 27, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany 317 Holland Street Cumberland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs, last birthday, **Funeral** Days 1 M 2 TF 67 213-40-2710 Director 05/18/1940 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 X Yes 2 ☐ No Director MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21502 permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examinar and once. 317 Holland Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No ð Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Uvada Robison Charles Trixie Gillum Selma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul F. Hollern / Husband 317 Holland Street, Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Cumberland Crematory 1/29/2008 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Parti. Enti Immediate Cause (Final **Physician** disease or condition resulting in death) Immediate Head Injury /Medical Due to (or as a consequence of): Examiner Suicide Sequentially list conditions, if any, leading to immediate cause. Enter Underf, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🎇 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy certificate 1□ Yes 2\ No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1X Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred
Jumped from 2nd story window 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: To the Hospital or Attending | within 24 hours after death.
To the Funeral Director: After Injury 5 Pending investigation 1 Natural thin 24 hours after continued to the Funeral Director: After continued to the funeral pitch of the funeral pitch of the funeral continued to the funeral continued to the function of the funeral continued to the function of 11:27 AM 1/27/2008 1 ☐ Yes 2 X No 2 Accident 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 317 Holland St, Cumberland, MD Alley 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D09157 January 28, 2008

43

State

Registrar JAN 2 9 20

31. Date filed (Month, Day, Year)

Paul Snow, M.D.,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ch Goarles

124 West Third Street, Cumberland, MD

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Lee Hancox January 29, 2008 1:05 A /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 831 National Highway LaVale Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral**  Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 ☐ M 2 💢 F 64 Director 239-72-3332 West Virginia 09/02/1943 Usual Residence of Decedent 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits MD Director Allegany LaVale 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 831 National Highway 21502 USA 2 should be filed within 72 hours after death v and Mental Hyglene. is marked other than "natural", or iteme 22e Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cramer Watson Gibson Mary Lee Coffindaffer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh
Department of Health and
Important: If item 27 is n
any injury or other traum Dean A. Hancox / Husband 831 National Highway, LaVale, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park 02/01/2008 Cumberland, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part I. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 7 to ym /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter or derlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). The law requires that the death certificate be executed physician and s the burial-transit Examir Due to (or as a consequence of) Physician/Medical as attending IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) ed by the a 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed?

1 Yes 2 No page certificate ! 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🕅 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ဥ this 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury After 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ⊟Natural (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

UHIVIH 17 Rev 1/2001

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number

D17565

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

January

29, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anthony J. Bollino, Jr., M.D., 922 National Highway, LaVale, MD 21502

State Registrar

JAN 29



For	State of Maryland / Department of Health a
State Registrar	Certificate of Death

and Mental Hygiene 2008 04828

			Registrar					Cer	uncai	e or t	Jealii		1	Reg. No.	0 0	0,000
	Physici	an	Decedent's Nam	. 11	-								2. Date of De.	Day	Year	3. Time of Death
	/Media		1/2 11	u Mod	- 0				45 O'5	T	Location	-4 D45	Janue		2008	
	Examir	ier	4a. Facility Name (						40. City,		Location				y of Deatl	
_			5. Social Security N	-	ehabilita 6.Sex		(In yrs. last t	nirth/day)	If Unde	r 1 Year	rtonsv If Under		R Date of Birt		lontgo	
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	lend		10a. State	10b. County			10c. City, To	wn or Lo	ation							10d. Inside City Limits
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	ne 2	Funeral Director	11. Marital Status	Offat C WC	12. Was D		ver in U.S.	13. V	Vas Dece	dent of H		·	ofy Yes or No lican, etc.)	- 14. Ra	ce - Ame	rican Indian,
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	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylend Depertment of Heelth and Mental Hygiene. Depertment of Heelth and Mental Hygiene. Important: if item 27 is marked other than "naturel; or items 23a or 28a-f show any injury or other treumatic event, The Medical Examinar must be notilled at ance.	Completed	/Sner	15. Decedent	's Education	(d)	16	a. Deced	ent's Usu	al Occupa	ation	at of workin	0	16b. Kind of	Business/	Industry
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ylallu	al Hy	Be	17. Father's Name	(First, Middle, L	_ast)						18. Moth	er's Name	(First, Middle.	Maiden Suma	me)	
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<u> </u>	and and is my		19a. Informant's N	ame/Relationsh	nip (Type, Print)		11	9b. Mailin	g Addres	s (Street a	and Numb	er or Rural	Route Numbe	er, City or Tow	n, State, Z	(ip Code)
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			23a. Part1. Enter the shock, or head	the disease, or	complications the	at caused	the death. D	o not ente	er the mo	de of dyin	g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between
	Pnysician		Immediate Cause disease or condition	(Final			ovasci	4	ace	Α.	1					Onset and Death
	/Medical		resulting in death)		- a		a consequence		مدور	, ( )	74 () -					
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ر د	et the	Physicia	9 Unknowr													
ń	igner bed	þ	Part II. Other signi	\ .		o death bi	it not resulting	g in the ui	nderlying	cause giv	en in Part	I.				the cause of death?
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<u> </u>	r Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 🗌 Could r determ	ined   289. Pl	ace of Inju	ury - At home, c. (Specify)	farm, str	eet, facto	y, office		2	8f. Location ( City or To		nber or Ri	ural Route Number,
2	rs aft	Se														
	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate hes been signed by the attending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Cheek only one)	1 Partityin 2 Medical	g Physician: To Examiner: On the	the best e basis of anner sta	examination	lgs, dsatt and/or in	onnuma vestigatio	at the tr n, in my o	ne data a pinion, de	nd place, a ath occurre	nd due to the dat the time,	date and place	and due	s stat5d a to the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04830 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Mollie Margaret Holley 0150 A M Jan.30,2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 042-16-0521 1 M 2 XF 86 6/10/1921 England Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 No Md.Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9701 20850 Veirs IISA Drive 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Timothy Fenton Bridget 0'Shea 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bauer Dr., Rockville, Md. 20853 Barbara Boyd -Daughter 14502 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St.Rose of Lima Cem. 2/2/2008 Short Hills, N.J. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Hysong Co. 2222-Wisconsin Ave., NW 21. Signature of Funeral Service Licensee M W Hysong Co. Washington, 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only in a cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis 4 Days Due to (or as a consequence of): 4 Days Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Pneurothorex 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Anemia 24a. Was an Was a. autopsy performed? 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner death certificate be executed

**Physician** 

/Medical

Examiner

Director

Funeral

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Physician/Medical

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Certification:

filled in by

27. Manner of Death

1 XNatural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show yill represent it item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural" or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at one.

5-0036

Itimore, Maryland 2121

Box 68760

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Division or Vital Records,

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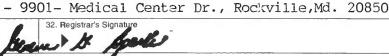
completely To the l within 2-State

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zhu Yao 31. Date filed (Month, Day, Year)

5 Pending investigation

6 ☐ Could not be



28a. Date of Injury (Month, Day Year)

and manner stated.

2008 **FEB 0 4** Registrar

29b. Signature and title of certifier

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

(m)

Injury

28c. Injury at Work?

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D53654

1 📉 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2/4/2008

29d. Date signed (Month, Day, Year)

Catherine Ibacache

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 04831

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1={	wohen	776	ole_		50	00 Uni	rersi	ty Bly	rd., W,	<ul> <li>S1Ive rrest, shock, or</li> </ul>	r Spr.	Approximate Intel
23a. F	ert I. Enter the disease,											Between Onset a Death
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even	ts resulting in death) Las	st Due	to (or as a consequ	ence of):								1
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일 그	· -					877_3.4	.08 TT			23d. Dat	te of delivery	<u></u>
	MALE: Was decedent pregnant i			of pregnar		Fetal death	3	Ectopic preg	nancy			Day Year
iai	past 12 months?	4		ne of death								
Z									on- Di	d tabassa iisa d	contribute to	the cause of death
	II. Other significant cor	nditions cor	ntributing to death b	out not resu	ulting in the	e underlying	ause give	n in Part I.				
b b									-	-		utopsy findings ava
ete									au	utopsy	prior to	completion of cause
립											1 🗸 Y	
	Was case referred to me	dical				2	6.Place of	Death (Che	ck only one)			
m l	examiner?		pital: Inpatien	t 2 E	R/Outpatie	ent 3 D	DA Ott	her <sub>4</sub> Nu				er: Scene
P 27.			28a. Date of Injury		28b. Time	of Injury 2	8c. Injury a	at Work?	28d. Descr	ibe how injury o	occurred	
<u>5</u> 1	Natural 5				Fod 11	1.30 pm	1 Yes	2 XNo	vehic	le fire		
2 Z			28e. Place of Inju	ry - At hon	ne, farm, s	treet, factory	office buil	ding, etc.	28f. Location	on (Street and I	Number or R	Route Number
₩ 3									7958 Ï	nverness	Ridge 1	Rd Potomac.
		ng Physician				1 . 1 1 1	atana alaman	and place,	and due to the	cause(s) and m	anner as sta	ated.
one (Ch	eck only 2 Medical	Examiner:0	n the basis of exam	nination an	d/or invest	tigation, in my	opinion, d	leath occurr	ed at the time, o			
29h			ng manner stated.							29d. Dat	e signed (N	Nonth, Day, Year)
_	m. L	· M	eo. n.	0			O.C.M	.E.		Februa	ary 12, 20	800
	- Julia			eath (Item	23a)							22
			sistant Medica	al Exami	ner 1	11 Penn S	Street, B	altimore,	MD 21201			
			32 Finistrar			Accept.						
Coloing the Day of the Charles	Medical Certification: 10 Be Completed by Planting Caussian Caussi	Immediate Cause (Final disea or condition resulting in death Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cau (Disease or injury that initiate events resulting in death) Last XUNPENDED  IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9   Part II. Other significant conditions are referred to me examiner?  1 Yes 2 No 9   25. Was case referred to me examiner?  1 Yes 2 No 9   27. Manner of Death  1 Natural 5 Natural 2 XAccident  3 Suicide 6 A Homicide  29a. Certifier 1 Certifying Check only one) 2 Medical  29b. Signature and title of conditions are referred to me examiner?  30. Name and address of particular and title of conditions are referred to me examiner?  31. Date filed (Month Pay)	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. 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Name and address of person who completed gause of death (Item Tasha Greenberg MD. Assistant Medical Examination and manner stated.  28. In the inhalation and Due to (or as a consequence of):  Due to (or a	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Cause. 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Was case referred to medical examiner?  1 Natural 5 Pending (Month, Day, Year)  27. Manner of Death Investigation Investigation Investigation as Suicide 6 Could not be determined (Specify) Outside of a residence  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dat	Interview List only one cause present disease or condition resulting in death)    Sequentially list conditions, if any, leading to immediate cause. 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List only one cause (pinal disease or condition resulting in death)  The properties of the pr	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially ist conditions:  Sequentially ist conditions:  If any, leading to immediate cause. Enter Underlying clause (Disease or Injury that lethics)  Expendition is a consequence of):  Due to (or as a conseque

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 VIRGINIA **JACKSON FEBRUARY** 3:30 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 20,1945 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 X F Months Days Hours Min. 215-44-4923 62 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Montgomery Damascus 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10904 Bethesda Church Road 20872 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 🗷 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) County Court 12 Administrative Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joy Jean Patrick Charles Orman Shoemaker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Jackson-Suthard/Daughter 10904 Bethesda Church Rd., Damascus, Md. 20872 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Laytonsville Cem. 2/7/08 Laytonsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee 20882 P. O. Box 5038, Laytonsville, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final piraturu disease or condition resulting in death) r as a consequent of): monas Vein Due to (o) as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Donknown 24a. Was an

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

Md.

**Funeral** 

Director

ns 23a or 28a-f show must be notified at

or items

"natural"

Examiner

traumatic event, the Medical

marked other

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Important: If it any injury or c

2 should be filed within and Mental Hygiene.

Pages 1 and 2 nent of Health a

Maryland

Baltimore,

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Vital Physician:

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Hospital or Attending Jophtan C.
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Therapid Director: After

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To the Funeral Dire

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Director

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Completed

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death with the Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner ing physician and sas the burial-trans attending physician for use as the buria

Completed by

Medical Certification: To Be

autopsy perform 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manper of Death

5 Pending 2 Accident investigation

6 ☐ Could not be

determined

28a. Date of Injury (Month, Day Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Varsing Home 5 A Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only

1 Naturai

3 ☐ Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year,

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thom

State Registrar

nhn 31. Date filed (Month, Day, Year) FEB 0 6

Modrose

08-01022 Thomas Jurgenson

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 04833

		- For State Registrar			Certin	ficate o	f Death	h			Reg	. No.		
Physicia		Decedent's Name (First, Middle	Month Day Year Open								3. Time of Death			
ledical Examin	ıer		Thomas Jurgenson institution, give street and number)  4b. City, Town, or Location or								ebruary 5,	2008	real	0056 hrs
		4a. Facility Name (if not institution	, give street a	and number)					ocation of	Death			unty of Dea	ith
		Howard County General	al Hospita				Colum	nbia				How	<i>r</i> ard	
Funeral		5. Social Security Number	6. Sex	7. Ag	e (In yrs. last	birthday)		er 1 Year	If Under		Date of Birth	(MM/DD/	YYYY) 9. E Fore	Birthplace (State or
Director	- 1	047 36 0444	1 X M 2	F	62	Yr		s Days	Hours	Min.	8/21/	1945	C	Country)Germany
	H	Usual Residence of Decedent												
any		10a. State 10b. County			10c. City, To	own or Loca	ition							10d. Inside City Limits
nd show	-	MD Howa	rd		Elli	cott (	City							1 Yes 2 X No
Maryland 28a-f show d at once	拔	10e. Street and Number					10f. Zip	Code			10	g. Citizen	of What Co	ountry?
death with the Maryland or items 23a or 28a-f sho must be notified at once	Director	3237 Ramblewood	Rd				21	042			1	Unite	ed Sta	ates
with (	- L	11. Marital Status	12. Wa	as Decedent	Ever in U.S.	13. W	as Decede	nt of Hisp	anic Origin	n? ( Specify	Yes or No-	14.		erican Indian, Black,
eath item ust b	Fune	1 Never Married 2 X Ma	rried Ari	med Forces? Yes 2	No	lf.	Yes, specif	y Cuban,	Mexican, F	Puerto Rica	n, etc.)		White, etc.	
		3 Widowed 4 Dive	orced If Yes, G			1	Yes 2	X No	specify:			Spe	ec <i>ify</i> : Wh	nite
urs a Itura	d b	15. Decedent's Education (Spec	ify only highe	st grade con	npleted) 1	6a. Decede					done	16b. Kind	of Busines	s/Industry
n "na	eted	Elementary/Secondary (0-12)	Col	lege (1-4 or	5+)	during i	most of wor	rking life. I	DO NOT u	se retirea)				
036 ithin 7; ne. r than	립		4			Cou	nselo	r				Н	meles	ss Shelter
5-0 led w tygie othe	Comple	17. Father's Name (First, Middle,	Last)							•	st, Middle, M		name)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Sigurd Kister									Kalbu			
21 nould d Me is ma tic es	-v	19a. Informant's Name/Relationsh												ate, Zip Code)
MD d 2 sho lth and n 27 is		Judith L. Jurge	nson/W	ife							cott (			
imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Innt: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition  1 Burial 2 X Cremation	3 Dem	oval from St		ace of Dispo ematory or o	osition (Nar other place)	me of cem )	ietery,	Da	ite	20c. Loc	ation - City	or Town, State
Pages ent of	- 1	4 Donation 5 Other Sp		oval nom o		ent C				2-6-2	8008	Hand	over,	MD
Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingury or other traumatic event, the Med	- 1	21 Signature of Funeral Service		110	M0104	4 22.	Name and	Address	of Facility	Harry	H. W	itzke	e's Fa	emily FH Inc.
<b>9</b>	- 1	Them Oth	s-W	you		4	112 O	old Co	olumb	oia Pi	ke EL	Licot	tt Cit	ty, MD 21043
Physician		23a. Part I. Enter the disease, or failure. List only one cause		that caused	the death. D	o not enter	the mode	of dying, s	such as ca	rdiac or res	piratory arre	st, shock,	or heart	Approximate Interval Between Onset and
Medical	- 1	Immediate Cause (Final disease	<sub>a.</sub> Head	Injuries										Death
raminer	- 1	r condition resulting in death)  Due to (or as a consequence of):												
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	Examiner	if any, leading to immediate cause. Enter Underlying Cause		or as a cons	equence of):									
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	an/	23b. Was decedent pregnant in the past 12 months?	1	Live birth			etal death	3	Ectopic	pregnancy		M	onth	Day Year
Records, P.O. Box 687 The law requires that the death certific cate has been signed by the attending I page 2 should be detached for use as the control of the stood of the st	Physician	1 Yes 2 No 9 Unit	nown d	Unknown	t time of deat	th 5 (	Other (Spe	ecify)				10		
be de shed f		Part II. Other significant condit	3		th hut not res	sulting in the	underlying	n cause n	iven in Par	41	23e. Did to	bacco us	e contribute	to the cause of death?
that the bedead	by	Hypertensive Atheros				_	, and any	3 3			1 Yes	2 1	10 3 F	Probably 4 V Unknown
ords, P.O. w requires that as been signed to should be deta	ed	Trypertensive / tarieros	0.0101010	ar are vale	diai Bioo					_	24a. Was a	an i	24b. Were	autopsy findings available
Corc law rec has be	음										autop			to completion of cause of
Rec The la	Completed										1 Yes		1 🗸	
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of Vital Records, P.O. or Physician: The law requires that the Physician: The law requires that the this certificate has been signed by neral director, page 2 should be detailed.	0	examiner? 1 ✓ Yes 2 No	Hospital	1 Inpati	ent 2 🗸 E	ER/Outpatie	ent 3 🔝 I	DOA	Other <sub>4</sub>	Nursing H	ome 5	Residenc	e 6 O	ther:
ion of Vital   tending Physiciau: teath. tor: After this certif	Ë	27. Manner of Death	28:	a. Date of Inj (Month, Day, eb 4, 2008		28b. Time o	f Injury		y at Work	lsu	d. Describe I bject fell	now injury	occurred	
ion tendi tor:	읉	1 Natural 5 Pend 2 ✓ Accident Inves	ding stigation	eb 4, 2008		2338 hrs		1Y	'es 2 <b>√</b>	No				
Division tal or Attendi rs after death.	<u>:</u>		d not be	e. Place of I	njury - At hor	ne, farm, st	reet, factor	y, office b	uilding, etc		or Town, S	itate)		r Rural Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Director:	Certification:		rmined (S	pecify) Si	ngle Fami	ily Home				323	37 Ramble	wood Ro	ad, Ellicot	tt City, MD
Hos 24 hc Fun etely		29a. Certifier 1 Certifying P	hysician: To	the best of n	ny knowledge	e, death occ	curred at th	e time, da	ite and pla	ce, and due	e to the caus	e(s) and	manner as	stated.
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical	one) 2 Medical Exa	and m	basis of exa anner stated	amination an	d/or investig				curred at th	e time, date			
F 2 F 5	Ň	29b. Signature and title of certifie	er				29	c. License						(Month, Day, Year)
		aue I						0.C.	M.E.			Febru	Jary 5, 20	308
6		30. Name and address of person	who complet	ed cause of								-		
EG.		Ana Rubio MD. Ass	sistant Me	dical Exa	miner 1	11 Penn	Street,	Baltimo	ore, MD	21201				
St	ate	31. Date filed (Month, Lay, Year)	5 2008		ar's Signatur	2	1.00							
Regist	rar	0	, 2000	Just	se of									

State Registrar

**ORIGINAL** 

WOLFE ST

BALTEMORE MD 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MASSOLID

6 2008 Registres Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician**  $A^{M}$ 19, 6:08 Edmonia Carlotta Johnson January 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring Montgomery 15301 Pine Orchad Drive, Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 🔀 F 85 Director 578-20-0218 12/27/1922 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 28a-f show :7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 TxYes 2 □ No Director Silver Spring MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 15301 Pine Orchad Drive, #30 20906 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 African 1 ☐ Yes 2 ☒ No Specify Specify: þ 3 ☐ Widowed 4 ☑ Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 d 2 should be filed w h and Mental Hygien 7 is marked other th Social Worker Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked o any injury or other transment. ပ Bedford Stokes Beatrice James 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Jacqueline Reeves / Daughter</u> 17716 New Hampshire Ave. Ashton, MD 20861 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/24/2008 Gate of Heaven Silver Spring 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc. Thompso -Inche 7400 Georgia Ave., N.W. Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Carcinoma of Lung with Metastasis 6 Months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transit Due to (or as a consequence of) Box 68760 attending physician Physician/Medical as the for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f ☐Yes 2XNo P.0 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð Congestive Heart Failure 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Diabetes Mellitus 24a. Was an certificate has performed' 1 Yes 2 TNo Hypertension Division or Vital 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending (Month, Day Year) 5 Pending investigation 1 K Natural 1 ☐ Yes 2 ☐ No after death. death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Roule Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I completely filled ī 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signatur and title of certifier 29d. Date signed (Month, Day, Year) MD25047 February 1, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lawrence R. Cannaday, M.D. Suite 305 South Washington, D.C. 20010 106 Irving St., N.W. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 5 2008 Registrar

			For State Registrar	State of Mar		artment o			•	ne nna	04837
	Physici /Medic			LCEANA JOH	HNSON			M C	2	Day Year 05 2008	3. Time of Death 12:15p M
	Examin	er		Largo		4b. City, Tor Largo			]		Georges
	Funeral Director		5. Social Security Number 150-20-4789	5. Sex 1 □ M 2 □ 7. Age (i 102	In yrs. last birthday) Yrs.		Days Hours	Min. 05,	ate of Birth 1901h Day Ye 130 / 190	95 New	thplace (State or Foreign ountry) Jersey
	a-f show	ctor	MD 10b. County Prince		oc. City, Town or Lo Upper Mar						10d. Inside City Limits 1,
	th with the 23a or 28 ust be not	Funeral Director	10e. Street and Number 13007 Brice	Court		10f. Zip Co 20	0774		10g.	Citizen of What Co	ountry?
9036	filed within 72 hours after death with the Maryland Hygiene, ther than "natural", or Items 23a or 28a-f show int, the Medical Evarial arreast be notified at	d by Funer	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Even Armed Forces? d i ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Deceden If Yes, specify 1 ☐ Yes 2 ☑	t of Hispanic Orig Cuban, Mexican, No Specify:	in? (Specify Y Puerto Rican	es or No- , etc.)	14. Race - Ame Black, Whi	te, etc.
Maryland 21215-0036	əd within 72 h /giene. ler than "natu	Completed by	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12th	grade completed) College (1-4or 5+)	(Give	dent's Usual C kind of work of DO NOT use i	done during most retired)			Privat	
yland	2 should be filed withir and Mental Hygiene. Is markad other than anmatic avant, Ive III.	To Be	17. Father's Name (First, Middle, L. Walter D. John	nson			Lute	tia	t, Middle, Maid Webb		
	and 2 sho ealth and n 27 Is m		19a. Informant's Name/Relationshi Marjory Powell	p (Type, Print)  Daughter	1300	7 Bri	.ce Court	Uppe	r Marll	ty or Town, State,	20774
10a. State   10b. County   10c. City, Town or Location   10c. City, Town or Location   10d. Inside City Ling   10d. Inside C											
	Pnysician /Medical		23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	nly one cause on each line.	ine To T	er the mode o	of dying, such as o	ardiac or resp	piratory arrest,		Approximate Interval Between Onset and Death  1 month
68760,	v requires that the death certificate be executed as been signed by the attending physician and should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Ener. Underlying Cause (Disease or injury that initiated events resulting in death) Last		estive H	leart	Failure				1 month
.O. Box 6	The law requires that lhe death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 [ 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregi ] Other <i>(speci</i>				23d. Date of de Month	livery Day Year
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I Records,	The lav ate has page 2	Completed						_	4a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of s 2 No
f Vital	> 0 0	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1  Inpatient	2 ER/Outpatier	nt 3 DOA	Cthor	of Death (Che sing Home		e 6 ☐Other (Spe	ecify)
Division of	ling After fune	Certification;	27. Manner of Death  1 🐼 Natural  2 🗆 Accident  3 Suicide  4 Homicide  6 Could nodetermin	t be	- At home, farm, str	М	. Injury at Work? 1 □ Yes 2 □ N	28f. L			ural Route Number,
ā	To tha Hospital or Attanc within 24 hours after death To tha Funaral Diractor: completely filled in by the		29a. Certifier (Check only)  2 Medical E	Physician: To the best of a	my knowledge, deat			place, and d	ue to the caus	e(s) and manner a	
	To tha I- within 24 To tha F complete	Medical	29b. Signature and title of certifier	and manner states  Mathew			icense number D 47			Date signed (Mon	th, Day, Year)
2	(5)		30. Name and address of person w	ho completed cause of deat	th (Item 23a) (Type, 48 Mitche	Print)	≥ Road•	Bowie	e, MD	20716	
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 7 2008	new, M.D. 30.  32. Registrar's	Signature		- nwi				

			For	State of Maryland /	Department of Health and M	fental Hygie	ne	01000
			1 - For State Registrar		Certificate of Death	Rag.	2008	04838
	Physici	an	1. Decedent's Name (First, Middle, Last			2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give	Street and number)	4b. City, Town, or Location of Death	-Uliv	99 2005 4c. County of Death	1:25 pm
	Examir	ier	and the second second	Neval Hospita	al Cambridge		Dorches	ster
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last I	birthday) If Under 1 Year If Under 24 Hts.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthple Count	ace (State or Foreign
	Director		214-12-5992 10 Usual Residence of Decedent	3 7	Yrs.	NOV. 1,19	150 Mar	yland
	/land	,	10a. State 10b. County	10c. City, To	own or Location	· · · · · · · · · · · · · · · · · · ·	10	d. Inside City Limits
$\overline{}$	e Man	ctor	MD Dorche	ster Ci	ambridge			1 Yes 2 No
7	vith th	Funeral Director	10e. Street and Number	-1 ,	10f. Zip Code	10g.	Citizen of What Count	ry?
3	eath v	erai	422- High S	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (So	ecify Yes or No-	14. Race - America	an Indian.
က	or Hen	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🗗 No	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, e	etc.
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show he Madical Exer-liter meat be multified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 P No Specify:		Specify: Blac	
15-	n 72 h	Completed	15. Decedent's Edu (Specify only highest grad	cation 16 9 completed)	Sa. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 16b	, Kind of Business/Ind	ustry
212	illed withir I Hygiene. other than	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	Never Worked	٨	lone	
	be filed stal Hygie od other	BeC	17. Father's Name (First, Middle, Last)	<u> </u>		e (First, Middle, Maid	den Sumame)	
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Maryland	permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. mportant: If item 27 is marked other than "n may Injury or other traumatic event, Ins Much. DES.		19a. Informant's Name/Rel tionship (7)	es, sig.	9b. Mailing Address (Street and Number or Rur +22-High Street Ca		•	
	s 1 en f Heal ftem 2 other		20a. Method of Disposition	20b. Place	of Disposition (Name of	Date 206	Location · City or Tox	wn, State
E E	Pages nent of int: If it ury or o		1  Burial 2  Cremation 3  F 4  Donation 5  Other (Specify)	ternoval from State	Field Cemetery 2/	2/08 C	hurch Cred	eK, MD.
Baltimore,	permit. Pag Department Important: any Injury ence.		21. Signature of Funeral Service Licens		22 Alama and Address of Escility			
	⊈0 E ∰ a		The San Estartha diagona or comp	- Coming	Henry Funeral Ho 510 Washingto	N St. Ca	ubridge,	MD. 21613 Approximate
			shock, or heart failure. List only o	ne cause on each line.	o not enter the mode of dying, such as cardiac	A A		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence	e of):	1 als	esi	
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Вох	ettend for us	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death			23d. Date of delive Month	ry Day Year
o.	the d	Physician/Med	1  Yes 2  No 9  Unknown	9□ Unknown	oner (apochy)			
Division of Vital Records, P.O.	Attending Physician: The law requires that the death certifica er death. ector: Afier this certificate has been signed by the ettending ph by the funeral director, page 2 should be detached for use as the	by P	Part II. Other significant conditions co	ntributing to death but not resulting	g in the underlying cause given in Part I.		co use contribute to th	
ord	een si	ted	Mail	el Kelesi	detion	1 ☐ Yes	2 No 3 Prob	ably 4 □Unknown
Rec	hasb ge 2 si	Completed				24a. Was an autopsy performed	prior to con	osy findings available npletion of cause of
E	ificate or. pag	မိုင်	25. Was case referred to medical		26 Place of Deal	1 ☐ Yes 2 ☐	No 1 ☐ Yes	2 No
<b>\frac{1}{2}</b>	Physicia this cert al direct	To B	eyaminer?	lospital: 1 Inpatient 2 ER/	Other		e 6 ⊡Other (Specify	9
آ 0	ing Pt		27. Manner of Death 1/□Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b	o. Time of 28c. Injury at Work?	28d. Describe how i	njury occurred	
isio	death death ctor: /	cati	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home,	M 1 Yes 2 No	28f Location (Stree	t and Number or Rura	l Route Number
<u>&gt;</u>	el or A s after it Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	anny and any and any	City or Town, S		
	fospital hours unere	ledical C	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of my knowled	dge, death occurred at the time, date and place, and/or investigation, in my opinion, death occur	and due to the caus	e(s) and manner as st	ated.
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medi	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		Date signed (Month, I	
	£.₹£.8		> Mellt.	MD	063359	256	1/20	108
•	(h		30. Name and address of person who co	empleted cause of death (Item 23a	a) (Type, Print)		1011	
			MAHBUBA 1	WHTER, 5	00 10 1111	PAMBRI	DGE, M	D-21613
	Sta Registr		31. Date filed (Month, Day, Year)	32. Refistrar's Signature	+ South			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2. U U 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner HUSpita( Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ■ M 2 F Director filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exeminer must be notified at any Injury or other traumatic event, the Medical Exeminer must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number Funeral Was Decedent Even Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) roduces Processor Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) VETNON JONES md 2072 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Crematury of Delmarun 2-11-08 Delmar, DE 4 □ Donation 5 □ Other (Specify) 21 Signature of Funeral Service 2. Name and Address of Facility Bennie Smith Fungral Hom 917 W. Isabella St Salisbury, md 21801 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician many years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine for use as the burial-transit Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burian Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dissele 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide determined 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Exam/ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier lly 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State 31. Date filed (Month, Day, Year)
FEB 0 5 2008

32. Registrar's Signature

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			For State Registrar	State of Marylan		artment of H <i>rtificate of L</i>			giene Reg. No.	2008	3 04840
	Physici		1. Decedent's Name (First, Middle, Last) Shirley Mae	Johnson				2. Date of De Month02		2008 Year	3. Time of Death 6:10 P M
3	/Medio		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of Death	1	4c.	County of Dea	th
			7959 Telegraph Rd	, Lot 157		Severn			A	nne Arı	undel
75	Funeral Director		216-31-5526		/ast birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird 07//13//1	1929)	9. Bir Taki	thplace (State or Foreign
	pug w		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation					10d. Inside City Limits
	f sho	ō	MD Anne Aru		evern						1 √EYes 2 □ No
	the 28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Co	ountry?
	3a or	Ö	7959 Telegraph Rd,	Lot 157			21144				USA
	death	Funeral		12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No	- 1	14. Race - Ame	erican Indian,
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 🗗 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 H No	Specify:	rtican, etc.)		Black, White	·
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and	< 5 m e	Be c	Warrenton Vivian J	a ola				Ophelia		ŕ	
2	should be fand Mental Is marked of umatic eve	ဥ	19a. Informant's Name/Relationship (Typ		19b. Maili	ng Address (Street a		_			Zip Code)
	and 2: ealth a n 27 Is er trat		Shirley Marinaro /	daughter	113 1	East H St	reet, Bru	nswick,	MD	21716	, ,
altimore,	_ +		20a. Method of Disposition	20b. F	Place of Disponent	osition (Name of matory or other plac	re)	Date	20c. Loc	cation - City or	Town, State
Ē	Page nent c ant: If		1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State		coln Cemet	1	6/2008	Bren	twood,	MD
Balt	permit. Pages 1 Department of H Important: If ite any Injury or ot once.		21. Signature of Funeral Service License	e 11. V	2	2. Name and Addres	ss of Facility FC	rt Linc	o1n	Funera	l Home
Ŋ,			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the deat						04, 110	Approximate Interval Between
Physician Immediate Cause (Final disease or condition resulting in death)  Congestive Heart Failure year year											
Medical resulting in death)  Due to (or as a consequence of):  Coronary Artery Disease											vears
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	ficate be executed physician and sthe burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Chronic Obst	tructiv	ve Lung D	isaease				years
Ö,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):						
58760,	ate be hysici the bu	dical	d								
_	ertific ling pl		IF FEMALE:	127							
P.O. Box	law requires that the death certificas been signed by the attending I should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☒ No 9 ☐ Unknown	3c. If yes, outcome pf pregnation  1 □ Live birth 2 □ Feta  4 □ Pregnant at time of compositions  9 □ Unknown	aldeath 3	□Ectopic pregnancy □ Other <i>(specify)</i>			2	3d. Date of de Month	livery Day Year
	res that igned by be deta		Part II. Other significant conditions con	tributing to death but not res	ulting in the u	inderlying cause give	en in Part I.	23e. Did to	obacco u	se contribute t	o the cause of death?
g	quires n sign uld be	d by	Arterial Fibrilati	on				1 🗆 '	Yes 2	<b>x</b> No 3□P	robably 4 Unknown
Records,	sIclan: The law require certificate has been sig irector, page 2 should b	Completed	Acute Cerebrovascu	lar Accident		<u> </u>		24a. Was autop	osy ormed?	prior to death?	utopsy findings available completion of cause of
Viitai	an: T tificate or, pa		25. Was case referred to medical				26. Place of Deat		2 No	1 ☐ Yes	s 2 No
	Physician: r this certifica ral director, p	o Be	examiner? 1 ☐ Yes 2 H No	lospital: 1 ☐ Inpatient 2 ☐	] ER/Outpatie	nt 3 DOA Othe				☐Other (Spe	ecify)
0	ding Phys n. After this funeral dir	L :u	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Injun		28d. Describe I			
000	endir sath. or: Af	atic	2 ☐ Accident investigation			M 1 1	Yes 2□No				
Division or	ospital or Attend hours after death. Ineral Director: / y filled in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Special	ome, farm, st	reet, factory, office		28f. Location (S City or Tox	Street and vn, State)	d Number or R	ural Route Number,
	T 4 F 9	Medical C	29a. Certifier (Check only one) 12 Certifying Phys 2 Medical Examin	sician: To the best of my knoner: On the basis of examination and manner stated.	owledge, deat ation and/or ir	th occurred at the tin	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		-	29c. License	e number		29d. Date	e signed (Mon	th, Day, Year)
			Solvaeun 1	uncus Peru	usen	11 V30	3912		CX	104/.	2008
R	(10)	ı	30. Name and address of person who co 1845 Oakwird	mple ed cause of death (Iter	n 23a) Type,	Print) 67	1912 Ien kni	nie 1	LU)	2106	. /
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 5 2008	32. Registrar's Signa							
		100	The second secon								

Amer	nded #23 , 01/30,	ВЪ, /08	per phy.	Plea ny Co.	ase Type or Pri State of M									
		-	For State Registrar		Otate of W	arylana /		tificate of			Cittaiiiy	Reg. No	200	8 04841
ų.	Physici		1. Decedent's Nam		le, Last) HERBERT		JU	DY			2. Date of Do		, 20 <b>0</b> 8	3. Time of Death 1300 м
	/Medic Examin				on, give street and number,			4b. City, Town,	or Location				County of De	
· ·	Funeral		5. Social Security N			ge (In yrs. last b	**	If Under 1 Yea			8. Date of Bi (Month, D	rth ay, Year)	9. E	Birthplace (State or Foreign Country)
No.	Director		233-50-3 Usual Residence o		1 <b>∑</b> M 2□F	78	Yrs.			1 1	MAR. 8			ST VIRGINIA
	laryland show ed at	_	10a. State	10b. County		10c. City, Tov						_		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the M 28a-f notifie	Director	10e. Street and Nu	mber	ERAL	FOR	r as	HBY 10f. Zip Code				10g. Cit	tizen of What	21
	th with 23a or ust be	ral Di	ROUTE 2	28				26719	9				U.S.A.	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland F Health and Mental Hyglene. It was 23a or 28a-f show frem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Marital Status		If Yes Give	No		Vas Decedent of f Yes, specify Cu □ Yes 2XN			cify Yes or N Rican, etc.)	0-	14. Race - Ai Black, W Specify:	merican Indian, hite, etc.  WHITE
215-0036	72 hour natural lical Ex	ted !		15. Decede	nt's Education est grade completed)		a. Deced	lent's Usual Occ kind of work don	upation	ast of workin	na		ind of Busine	ss/Industry
2121	filed within 7 Hyglene. other than "r oth, the Med	Completed	Elementary/Second 12		College (1-4or	5+)	life. D	SS PROD	ed)	of working	,g	1	VD GLAS	RGH PLATE SS CO.
pu	2 should be filed and Mental Hygi Is marked other aumatic event, ti	Be C	17. Father's Name	-	, Last)			·	1		(First, Middle		,	CON
Maryland	should be and Mental and Mental marked o	ဥ	19a. Informant's N		ship (Type, Print)	19	b. Mailin	g Address (Stre					A ANDER	
	and 2 sealth ar		SYLVIA	JUDY /	/ WIFE			O. BOX 8	37, FC				26719	
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If item 27 is any injury or other tra		20a. Method of Dis 1 XBurial 2 4 ☐ Donation	☐Cremation	3 □Removal from State Specify)	cemet	ery, cren	sition (Name of natory or other p Y CEMET]	· · · · · · · · · · · · · · · · · · ·		ate 0/2008			or Town, State
Balti	permit. Departr Importa any inji		21. Signature of F	uneral Service	Licensae Leganeur	'/	22	Name and Add UPCHURO P.O. BO	CH FUN	VÉRAL	HOME,	INC.	WV 26	5719
	Physician		shock, or her Immediate Cause	art tallure. Lis (Final	or complications that cause at only one cause on each	ine.			ying, such a	as cardiac o	r respiratory	arrest,	30.3-5	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	on		a consequence		FRICE	-1 4	113	CAS			years
B.,	ted sit	Examiner	Sequentially list co cause. Enter Und Cause (Disease of	onditions, erlying	b. Due to for as	a consequence	of]:							
,092	te be executed ysician and ie burial-transit	_	that initiated event resulting in death)	s Last	c. Due to (or as	a consequence	of):							
Box 6876	death certificate be sattending physicia I for use as the bu	//Medi	IF FEMALE: 23b. Was deceder		23c. If yes, outcome	e pf pregnancy							23d. Date of	delivery
P.O. Bo	that the death cer ed by the attendir detached for use	Physician/Medica	in the past 12 1  Yes 2 9  Unknow	nonths?		2 □Fetal deat at time of death		Ectopic pregnar Other <i>(specify)</i>					Month	Day Year
rds, P	w requires that s been signed k : should be det				ions contributing to death	_		, ,	jiven in Part	t I.				e to the cause of death?  Probably 4 Unknown
Vital Records,	e le ha:	Completed by										s an opsy ormed? 2 No	prior death	
Vita	slclan: Th certificate irector, pag	Be	25. Was case refe examiner? 1 ☐ Yes 2	1	Hospital:	ent 2 EB/O	utnation	t 3 DOA	ther:		(Check only		л Понь //	
1   Yes   2   No   No   No   No   No   No   No										респу)				
Divis	al or Atte s after des al Directo	Sertifica	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could deter	Zoe. Flace of it	jury - At home, t tc. <i>(Specify)</i>	arm, stre	eet, factory, offic	е	2	8f. Location City or To	(Street a own, Stat	nd Number or e)	Rural Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	Medical (	29a. Certifier (Check only one)	1 Certifyi 2 Medica	Ing Physician: To the besi I Examiner: On the basis and manner s	of examination a	ge, death ind/or inv	occurred at the vestigation, in m	time, date a y opinion, de	and place, a	and due to the	e cause(s e, date ar	s) and manner nd place, and	as stated. due to the cause(s)
		Σ	29b. Signature and	title of certifi	er 1	DN			nse number	2929				onth, Day, Year) , 2008
	5 +		30. Name and add	ress of persor	n who completed cause of	death (Item 23a)	(Type, I		62	- 12 1				
	n Ls		EMMAN 31, Date filed (Mod		OSEI-BO	AMAH rar's Signature	MDE	500 ME	MORI	ALA	WE, C	UME	SCRLAN	ND ND 21502
ì	Sta Registr			3 0 20	/8/		port							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death JANUARYP<sup>ay</sup>30, Ž**r**os **Physician** 6:40A M Margaret A. Kimura /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 8, 1934 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X F 294-30-2895 73 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural" or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐¥es 2 ☐ No Director Harford MD Abingdon 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21009 U.S.A. 415 Arrow Wood Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Household 12 Pages 1 and 2 should be filed v tront of Health and Mental Hygie tant: If item 27 Is marked other t Jury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William J. Higgins Margaret J. Offinger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shinjiro A. Kimura/Husband 415 Arrow Wood Ct., Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Important: If ite any Injury or o February 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Ferris Inc. 4 ☐ Donation 5 ☐ Other (Specify) 1, 2008 West Chester, PA 21. Signature of There Service Licensee 22. Name and Address of Facility Andrew G. Gee Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mole of lying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD 21921 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIO RESPIRATORY ARREST disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner VENTRICULAR ARRHYTHMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed burial-transit ACUTE MYOCARDIAL INFARCTION and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician CORONARY ARTERY DISEASE Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Por Day in the past 12 months? Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown ANOXIC ENCEPHALOPATHY Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes ②□ No 24a. Was an LATIC ACIDOSIS autopsy performe certificate 1∐ Yes 2. No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nnpatient 2 ER/Outpatient 3□ DOA Certification: To this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending investigation M 1 □ Yes 2 □ No To the Hospital or Attend within 24 hours after death To the Funeral Director: 2 ☐ Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

State Registrar FRANCIS

31. Date filed (Month, Dav. Year)

FEB

TAT-TEE

1 2008

DHMH 17 Rev 1/2001

KH00 M.D.,

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** Willie Jean Kammer 23:35 PM January 31. 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Manor Healthcare Center Ceci1 Rising Sun If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2X X June 27, 1931 76 Tennessee Director 216-28-3160 Usual Besidence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director Maryland Ceci1 North East 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 100 Willard Drive 21901 United States Funeral iral", or items 2 Examiner mus Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify Specify: White þ 3 ♥Widowed 4 Divorced "natural", Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other i any Injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Burke Laura Ora Bunch ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) George Mease / Son 100 Williard Drive, North East, Maryland 21901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition February 1 ☐ Burial 2 【Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State Mayerdale Crematory 1, 2008 Newark, Delaware 21. Signature of Funeral Service Licens 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** erebral Va /Medical Due to (or as a consequence of) **Examiner** enebra Squentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknow à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ A No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a, Was an per tension has autopsy performed? Yes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 ☐ Yes 1 Inpatient 2 ER/Outpatient မ After this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours a er death To the Funeral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 Cottin COLONIAL 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** CYNTHIA KIRKLAND JAN. 25, 2008 10:56A M /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
N.C. . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 1 ☐ M 2 🔽 F 242-84-9664 Director 58 Feb. 6, 1949 Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 Yes 2 No Director Maryland Prince Georges Forestville 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 20747 2000 Ode Road U. S. A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the M Social Security Administration Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lula Edmondson Eli Harding 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Franklin Kirkland - hus**b**∂nd 2000 Ode Road Forestville, Maryland 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2X1Cremation 3 ☐ Removal from State Riverdale Crematory 02/05/2008 Riverdale, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 3831 Georgia Avenue, N.W. Washington, D.C. 20011 MD 278 Latney's Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) o covolis NITE /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine requires that the death certificate be executed burial-tra Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical the IF FEMALE use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown by signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed Insufficience 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page certificate 2 No 1∐ Yes funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient P After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No death, 2 Accident Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide hours after thin 24 hours at the Funeral C 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 2 29b. Signature and title of certifier January 27, 2008 FODRIE D40324 (6) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TERRY JODRIE, MD 7503 SURRATIS ROAD, CLINTON, MARNLIAND 20735 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 05 2008 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		,	Cei	rtifica	te of L	Death			Reg. No	200	8	04	846
			Decedent's Name (First, Middle, La.	st)							2. Date of De	eath			3. Time of	Death
3	Physici		Khiyena Ki	melman							Month Februar	Da:			6:46	5 ам
To the	/Medic Examir		4a. Facility Name (If not institution, giv	e street and number)			4b. City	, Town, or	Location	of Death		*	County of D			
			Suburban H	ospital					Beth	nesda			Mo	ntgo	mery	
gi bra	Funeral		5. Social Security Number 6. S	Sex 7. Age	(In yrs. la	st birthday)		er 1 Year	If Under	24 Hrs. Min.	8. Date of Bi (Month, Da	rth		Birthpl	ace (State of	r Foreign
	Director		217-45-7353	□M 2⊠F	91	Yrs.	Months	Days	Hours	WIIII.	January			Count	Russi	_a
	P		Usual Residence of Decedent													
	rylar how	L	10a. State 10b. County		10c. City,	Town or Lo	cation							10	d. Inside Cit	
	e Ma a-f s tifiec	cto	Maryland Mont	gomery			G	ermant	own						1 TYes	2½ NO
	th th or 28 e no	Director	10e. Street and Number				10f. Z	ip Code				10g. Cit	izen of What	Count	ry?	
	th w 23a ust b		20418 Foxwood T	errace					20876	6			U.	S.A.		
	r dea	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S	. 13. '	Was Dec	edent of Hi ecify Cuba	ispanic Or ın, Mexica	rigin? (Spe	ecify Yes or No Rican, etc.)	0-	14. Race - A Black, W			
98	afte or it	y FL	1 Never Married 2 Married	1 ☐ Yes 2 🔀 N If Yes, Give	0	- 1		2⊠ No	Specify.				Specify:			
ğ	ural"	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:	- 1	10.		10				1 401 14			ite	
<u>r</u>	should be filed within 72 hours after death with the Maryland and Mental Hyglene. It marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)		16a. Dece	kind of w	ual Occup: ork done d use retired	durina mos	st of worki	ng	16b. K	ind of Busine	ss/Ind	ustry	
7	withir	ם	Elementary/Secondary (0-12)	College (1-4or 5- 4	+)	me. i	DONOT	Teach					Educa	+i or		
2	Hygie Hygie Ither		17. Father's Name (First, Middle, Last		1			Teach		er's Name	(First, Middle	Maiden		LIUi	<u> </u>	
ŭ	ntal I ed oi	Be							101111041				,			
Ž	12 should be filed v h and Mental Hygie 7 Is marked other t raumatic event, th	2	Mark Kimelm  19a. Informant's Name/Relationship (			10b Mailir	a Addro	o (Stroot	and Numb		Maria al Route Numl	Unkno		o 7in	Cadal	
Baltimore, Maryland 21215-0036	d 2 sl th an 7 Is r traur		Yakov Shapiro -	,			-	•			antown,				Dode)	
e,	iges 1 and 2 should be filed within 72 hours after death with the Marylar nt of Health and Mental Hyglene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition	5011	20b. Pla	ace of Dispo			DIIVe		ancown,		ocation - City		vn State	
٥	Pages nent of H ant: If ite ury or of		1 🔀 Burial 2 ☐ Cremation 3 ☐		cei	metery, crei	natory or	other plac	· i	00/01	- /0000		,			
Ħ	t. Pë rtmei rtant njury		4 □ Donation 5 □ Other (Special		Jua	ean Mer			i		5/2008	011	ney, Mar	ута	na	
Ba	permit. Pages 1 and 2 Department of Health s Important: If Item 27 Is any Injury or other tra once.		21. Signature of Funeral Service Lice	See See See		H	ines-	and Addres Rinald	i Fune	eral H	ome, Inc					
			23a. Part1. Enter the disease, or dom	Zuden	TOP						nue, Sil		pring,	Mary		
I)		8	snock, or neart failure. List only	one cause on each lin	e.	Do not en	er the mic	ode or dyin	ig, such as						Approximate Interval Bety Onset and D	veen Death
à	Physician		Immediate Cause (Final disease or condition resulting in death)	a. CO	PON A	ARY	A	RTE	ny	0	ISEA	SE				
	/Medical Examiner		resulting in death)	Due to (or as a	conseque	ence on:			- 2							
		L	Sequentially list conditions,	b										+		
12	ed sit	ine	cause. Enter Underlying Cause (Disease or injury	Due to or as a	conserue	ence on:										
V	ritificate be executed ng physician and s as the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a	conseque	ance of):										
9	be exician buria			220 10 (0. 20 1												
68760,	physi the	Medical		_d										+		
	ing unit		IF FEMALE:	23c. If yes, outcome p	nf nrecnan	CV							001 5-1			
Box	eath ce attendii for use	Physician/	23b. Was decedent pregnant in the past 12 menths?	1□Live birth 4□Pregnant et	2 Fetal of	death 3[	]Ectopic	pregnancy	•			Ϋ́	23d. Date of Month			<b>r</b> ear
o.	The law requires that the death to has been signed by the atter bage 2 should be detached for u	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	unie oi dec	atti JL	J Other (s	эреспу) —								
P.0	that the by detac		Part II. Other significant conditions of	contributing to death bu	it not result	ting in the u	nderlying	cause give	en in Part	I.	23e. Did	tobacco	use contribut	e to th	e cause of d	eath?
Vital Records,	sign d be	l by									1 🗆	Yes 2	<b>Z</b> ÎNo 3□	Prob	ably 4 ∐U	Jnknown
Ö	w requir been si should	Completed									04-144		1		C . P	
ě	has l	ldπ										s an opsy formed?	24b. Were prior death	to con	sy findings a apletion of ca	ause of
<u></u>		8									1□ Yes	2 <b>A</b> NO			215116	
ĬĬ.	ician certifi ector	Be	25. Was case referred to medical examiner?	Hospital:				Oth			(Check only					
0	Attending Physician: The reath. ector: After this certificate he ector: After this certificate he by the funeral director, page	은	1 Yes 2 Along the	1 🔲 Inpatiei		R/Outpatier 28b. Time o			4111		me 5 Res			Specify	)	
Division or	ing l After uner	Ö	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		Injury		28c. Injur Worl		.	28d. Describe	now inju	ry occurred			
Sic	tend leath tor: ,	cati	2 Accident investigation 3 Suicide 6 Could not b		A4 b		M		Yes 2		201 1 1'	(0)	- 1 1 1 - 1		De de M	
<u>&gt;</u>	or Attendation after death Director: in by the	Certification:	4 ☐ Homicide determined	28e. Place of inju building, etc	. (Specify)	ne, rarm, str	eet, racto	iry, office			28f. Location City or To			r Hura	Houte Num	ber,
	urs a		One Continue 4 Month to 19	uniciam. To the best of	of man lemans	dedoe dest	h	ما هد الم					) and mann -		at a d	
	Hosi 24 ho Fune Fune	ica		nysician: To the best of miner: On the basis of	examination											.)
	To the Hospital or Atte within 24 hours after dea To the Funeral Directo completely filled in by th	Medical	29b. Signature and title of certifier	and manner sta	ieu.		2	9c. License	e number			29d Da	ite signed (M	onth	Dav. Yearl	
	7. ≱ <b>7</b> . 8	_	255. Signature and the or certifer	Bus,	114.	`			5	7/3	4		2141			
1			In	4				960	) )		1	4	-171	0 1		
			30. Name and address of person who					01 5	.1	1 - 1	1	00000				
			Truong Bao, M.D., 31. Date filed (Month, Day, Year)						ckvil	ie, Ma	ryland 2	20850				
	Sta Registi		FFR 0 5 2	32. gistra	Joignall	K A	2001									
			PED VOL													

Kimelman, Khiyena a/4/08 olu4le

			For State Registrar	State of Marylar		rtment of H tificate of L		_	giene Reg. No. 2 () (	04847			
Ļ	Physici	an	Decedent's Name (First, Middle, L     MOHAMMED	AST) KAMARA		· · · · · · · · · · · · · · · · · · ·		2. Date of De Month	Day Y	3. Time of Death			
	/Medio		4a. Facility Name (If not institution, gi	ve street and number)			Location of Death	JANUARY	4c. County of	8:45 A Death			
	F		HOLY CROSS HC  5. Social Security Number 6.	SPITAL  Sex 7. Age (In yrs.	last birthday)	SILVER	SPRING If Under 24 Hrs.	8. Date of Birl	MONTG	). Birthplace (State or Foreign			
81.	Funeral Director		212-27-1515	1⊈M 2□F 52	Yrs.	Months Days	Hours Min.	(Month, Da	y, Year) 1907	Country REETOWN IERRA-LEONE			
	yland now at		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits			
	the Mar 28a-f sl	ector	MD PRINCE (	GEORGE'S	NEW CA	RROLLTON 10f. Zip Code			10g. Citizen of Wh	1 🕅 Yes 2 🗆 No			
	th with 23a or 1st be n	al Dir	7719 RIVERDALE	RD # 303		20784	4		USA	at ocumy.			
036	be filed within 72 hours after death with the Maryland that Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba I □ Yes 2⊠ No	Ispanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No p Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. BLACK			
21215-0036	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's E (Specify only highest g Elementary/Secondary (0-12)	ducation rade completed)  College (1-4or 5+)  3 YRS	16a. Deceo (Give life. L	lent's Usual Occupi kind of work done o OO NOT use retired ENTREPREI	during most of wor l)	king	16b. Kind of Busin	·			
Maryland 2	be d all eve	To Be Co	17. Father's Name ( <i>First, Middle, Las</i> BAI KAMARA						l , Maiden Surname) )H	· · · · · · · · · · · · · · · · · · ·			
	± 7 ₹ 6		19a. Informant's Name/Relationship OSMAN JALLOH/C		19b. Mailin 4513	g Address (Street a	and Number or Ru ROAD LAI	ral Route Numb NHAM, MA	er, City or Town, St ARYLAND 20	ate, Zip Code) 0706			
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition  1 □ Purial 2 □ Cremation 3    4 □ Donation 5 □ Other (Spec		ty or Town, State  N, SIERRA LEONE  NERAL HOME								
ñ	Dep Imp any onc		* Nearly	educe			OVER ROA	D LANDO	VER, MARYI				
	Physician /Medical		23a. Part1. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  PULMONARY EMBOLISM  Due to (or as a consequence of):  MYOCARIDAL IN FARCTION										
	Examiner	<u>-</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. MYOCARIDAL		CTION							
58760,	icate be executed physician and s the burial-transit	al Examiner											
P.O. Box 687	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 □Live birth 2 □ Fetr 4 □ Pregnant at time of 6			23d. Date Montl						
ecords, P	w requires that been signed b should be deta	ğ	Part II. Other significant conditions	contributing to death but not res	ulting in the ur	nderlying cause give	en in Part I.			ute to the cause of death?  ☐ Probably 4 ☐ Unknown			
r		Completed						24a. Was auto perfo 1∐ Yes	psy pri- prmed? de	ere autopsy findings available or to completion of cause of ath? ]Yes 2[X]No			
<u> </u>	ysiclan is certifi director	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🎇 No	Hospital: 1X Inpatient 2	ER/Outpatien	t 3 DOA Othe	26. Place of Dea er: 4 ☐ Nursing H	,	one) dence 6 □Other	(Specify)			
ion or	nding Ph ath. r: After thi e funeral	ation: T	27. Manner of Death  1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Worl			how injury occurred				
Division	tal or Attendii s after death. al Director: A ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, stre	eet, factory, office		28f. Location (S City or Tot		or Rural Route Number,			
	To the Hospital or Attending Physician: within 24 hours after death  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical (		hysician: To the best of my knowning. On the basis of examination and manner stated.		vestigation, in my o	pinion, death occu						
Į.	To t To t	Σ	29b. Signature and title of certifier	0 (101	1	29c. License			29d. Date signed (				
0	12)		30. Name and address of person who		n 23a) (Type,		0826		FEBRUAI	RY 1, 2008			
			KSHAMA GARG M 31. Date filed (Month, Day, Year)	D. 1500 FOREST	GLEN	ROAD SIL	VER SPRIM	√G, MARYL	AND 20910	)			
4	Sta Registr	÷ .	FEB 0.6 2008	32. Registrar's Sign	and I								

			State of Marylan  1 - State Registrar	-	rtment of F		•	giene	8 1840 8
	Physicia	an	1. Decedent's Name (First, Middle, Last) Albert C. Kitlas		-		2. Date of De Month	ath Day Ye	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give street and number)			r Location of Deat	DANUARY	4c. County of [	Death
	Funeral		Baltimore Washington Medical Cer 5. Social Security Number 6. Sex 7. Age (In yrs.		If Under 1 Year	Burnie  If Under 24 Hrs.	8. Date of Bir	th 9	Arunde1  Birthplace (State or Foreign
	Director		081-14-7090 1™ 2□F 86	6 Yrs.	Months Days	Hours Min.	12/25	1921	Birthplace (State or Foreign Country) NY
	ryland how at			ty, Town or Loc					10d. Inside City Limits
	the Ma 28a-f s notified	Director	10e. Street and Number	Juenton	10f. Zip Code			10g. Citizen of Wha	1 ☐ Yes 3€ No
	th with 23a or ust be	ral Di	518 Williamsburg Lane		2111			USA	
0500-0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ➡ Widowed 4 □ Divorced  12. Was Decedent Ever in U. Armed Forces?  1 ☒ Yes 2 □ No 194  15 Yes, Give Year or Dates:	43-	Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 ANo	lispanic Origin? (S an, Mexican, Puer Specify:	specify Yes or No to Rican, etc.)	14. Race - / Black, \ Specify:	American Indian, White, etc. White
2	"natur	leted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occup kind of work done of OO NOT use retired	oation during most of wo	rking	16b. Kind of Busin	ess/Industry
7   7	d withir giene. er than the M	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Offi				US Arm	ny
yland	ld be file ental Hy <b>ked oth</b> ic event	To Be (	17. Father's Name ( <i>First, Middle, Last)</i> Lucian Kitlas			18. Mother's Nar Mary Mas		, Maiden Surname)	
lary	2 shou and M Is mar raumat		19a. Informant's Name/Relationship (Type. Print)					er, City or Town, Sta	,
ē,	t and Health		Albert Kitlas Jr. Son  20a. Method of Disposition 20b. F		ron Corn sition (Name of natory or other place		Odenton,	MD 21113 20c. Location - City	
paritino	Pages ment of ant: If I ury or			lington	Nationa	1  3/11	/2008	Arlington	-
	permit. Depart Import any inj		21. Signature of Funeral Service Licensee		Name and Addre	-	_	Tuneral Ho s, MD 2140	
ħ	600		23a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.					rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence)						
	Examiner	L	Sequentially list conditions, if any leading to immediate b. Due to (or as a conseq						
	uted d ansit	Examiner	if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequent of the consequence of the conseq	juence or):					
0/00,	icate be executed physician and s the burial-transit	al Exa	resulting in death) Last Due to (or as a conseq	(uence of):					
0	tificate ng phys as the	Medical	d	000000	2°		-	1	51
O. DOX	To the Hospital or Attending Physician: The lay requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director. Page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnat 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	al death 3 🗌	Ectopic pregnancy Other <i>(specify)</i>	у		23d. Date o Month	
Ų.	es that t gned by se detac	by Ph	Part II. Other significant conditions contributing to death but not res		iderlying cause giv	ren in Part I.			ite to the cause of death?
cords	require		Liver Cirrhosis	,			1 2		☐ Probably 4 ☐ Unknown
ב ב	The lav te has age 2 :	ompleted					24a. Was auto perfo	psy prio prmed? dea	re autopsy findings available r to completion of cause of th? Yes 2 X No
NII'd	ician: certifica ector,	Be C	25. Was case referred to medical examiner?  Hospital: 454 Innation 1 OF		Oth	OF.	ath <i>(Check only o</i>	one)	
0	ng Phys (fter this uneral dir	on: To	1 ☐ Yes 2 ☐ No 1 I I I I I I I I I I I I I I I I I I	ER/Outpatient 28b. Time of Injury	28c. Injur Wor	y at k?		dence 6 ☐Other ( how injury occurred	(Specify)
JIVISION OF	Attendir death.	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At h	ome, farm, stre		Yes 2 □ No	28f. Location (	Street and Number of	or Rural Route Number,
5	oital or urs afte eral Dir		a Dulluling, etc. (Special				City or To		
	n 24 hor ne Fune oletely f	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my known one)  1 Medical Examiner: On the basis of examinar and manner stated.	ation and/or inv	estigation, in my o	opinion, death occ	urred at the time,	date and place, and	due to the cause(s)
	To th withii To th comp	Me	29b. Signature and title of certifier  Hannder Singh A	no a Ma	29c. Licens	e number	1	29d. Date signed (A	Month, Day, Year)
			30. Name and address of person who complet a cause of death (Iten	m 23a) (Type,	Print)	00121		JH WUAK	Month, Day, Year) Y 29, 2008 D 21061
1	411		HARVINDER SINGH ARORA 31. Date filed (Month, Day, Year) 32 Registrar's Signa	BW ature	MC Hos	PITAL C	ILENBU	RNIE, M	D 21061
	Sta Registr		FEB 0 1 2008	& L	sel.				

DHMH 17 Rev 1/2001

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Hours

CENTREVILLE

Days

**EUGENE FRANCIS KELLY** 

301 HOPE ROAD

5. Social Security Number

4a. Facility Name (If not institution, give street and number)

1**▼**M 2□ F

Months

Age (In yrs. last birthday)

Yrs

80

30

2008

QUEEN ANNE

4c. County of Death

2. Date of Death

8. Date of Birth (Month, Day, Year,

JANUARY

10:57 AM

Birthplace (State or Foreign Country)

**Funeral** 

death certificate be executed burial-tran for use funeral director.

MARYLAND Director 219-22-0354 OCT. 4, 1927 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If liem 27 is marked other than "natural" or freme "non-the trainment." 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No CENTREVILLE Director MD QUEEN ANNE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21617 USA 301 HOPE ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) STEEL INDUSTRY ACCOUNTANT 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **EVELYN RAYNOR** JOSEPH NORWOOD KELLY 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICK DEAN KELLY/SON 301 HOPE ROAD, CENTREVILLE, MD 21617 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition CHESAPEAKE CREMATION 1 ☐ Burial 2 Incremation 3 ☐ Removal from State 5 Other (Specify) 1-31-2008 STEVENSVILLE, MD 21666 4 Donation CENTER 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 408 S. LIBERTY ST., CENTREVILLE, MD 21617 ased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ach line. 23a. Part . Enter the disease, or complications that shock, or heart failure. List only one cause of Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC PROSTATE CANCER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA ို 1 Inpatient 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cirtifie D36054 1-31-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, 120 SPEER ROAD, BUILDING B, CHESTERTOWN, MD 21620 PATRICK J. SHANAHAN, 32. Register's Signature 31. Date filed (Month, Day, Year) State JAN 3 2008 Registrar

Records, P.O. Box 68760 Division or Vital

		1 - For State Registrar	State of Mar		ertificate of			Reg. No.2 ()	08	04850	
Physic /Medi		1. Decedent's Name (First, Middle, La Olga	est)		Kirkə		2. Date of Dea	y 29, 2	008	3. Time of Death 1:03P M	
Exami		4a. Facility Name (If not institution, given 14510 Homecrest	Road, #1001		4b. City, Town, 6	or Location of Death Spring		4c. County	of Death ntgom	ery	
Funeral Director			Sex 1 □ M 2 【XF	In yrs. last birthday 90 Yrs.	// If Under 1 Year Months Days		8. Date of Birth (Month, Day Nov • 12	,1917	9. Birthpi Coun Penn	lace (State or Foreign try) sylvania	
Maryland -f show ied at	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgome		Oc. City, Town or I					10	0d. Inside City Limits 1 □Yes 2 XNo	
3a or 28a st be notif	Funeral Director	10e. Street and Number 14510 Homecrest I	Road, #1001		10f. Zip Code 20906			10g. Citizen of V Uni tec			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Even Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	er in U.S. 13	. Was Decedent of lf Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Rac Blac Specify	e - America ck, White,		
thin 72 house. Ie. Ian "natura Medical E	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed)  College (1-4or 5+)	(Giv		during most of world ed)	- 1	16b. Kind of Bu			
d be filed wi ental Hygien ked other th c event, the	To Be Con	17. Father's Name (First, Middle, Las Karl Kirka		4   Manag	gement Ana	alyst   18. Mother's Nam   Anna Ber	ne (First, Middle,	U.S. GO Maiden Surnan		nent	
and 2 shoul salth and Ma 27 Is marl er traumati	F	19a. Informant's Name/Relationship Francis Yeatman -		8120	) Woodmon	•		hesda,	Mary]	land 20814	
t. Pages 1 rtment of He rtant: If iten rjury or oth		20a. Method of Disposition  1 Burial 2 Cremation 3 [ 4 Donation 5 Other (Speci	fy)	Cedar Hi		ery   2/1/		Suitlan	nd, Ma	eryland	
permi Depar Impor any ir		21. Signature of Funeral Service Lice	ngwast	D 4	onald V. 400 Powde	Borgwardt er Mill Ro	: Funera ad Belt	1 Home, sville,	PA Mary	land 20705	
Physician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	Arter:		nter the mode of dy		or respiratory ar	rest,		Approximate Interval Between Onset and Death	
ifficate be executed xB physician and set the burial-transit as	edical Examiner										
death certi e attending d for use a	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1 □ Yes 2 ☑ No 9 □ Unknown			te of delive	ery Day Year					
requires that the een signed by th nould be detache	by P	Part II. Other significant conditions	contributing to death but r	not resulting in the	underlying cause gi	iven in Part I.	23e. Did to	10	tribute to th	ne cause of death?	
The law recate has bee	Completed						24a. Was autop perfo 1 Yes	rmed?	prior to cor	psy findings available inpletion of cause of	
sician s certifi irector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpati	ent 3□ DOA Ot	26. Place of Dea	th <i>(Check only o</i> ome <b>X</b> Resid		es (Cassif		
To the Hospital or Attending Physician: The law within 24 burus after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	28b. Time	of 28c. Inju		28d. Describe h			y) 	
tal or Att rs after de ral Direct ed in by 1	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined			street, factory, office		28f. Location (5 City or Tox	Street and Numb vn, State)	er or Rura	d Route Number,	
n 24 hour n 24 hour ne Funer sletely fills	edical (	29a. Certifier 1	hysician: To the best of miner: On the basis of example and manner state	xamination and/or	ath occurred at the investigation, in my	time, date and place opinion, death occu	, and due to the irred at the time,	cause(s) and madate and place,	anner as s and due to	tated. the cause(s)	
λ	Me	29b. Signature and title of certifier	Sand	QH	29c. Licen DO58	ise number 309		29d. Date signe Janua:		Day, Year) , 2008	
D		30. Name and address of person who	completed cause of deal			Road Olr	nev. Mar	vland 2	0832		

Registrar
DHMH 17 Rev 1/2001

State

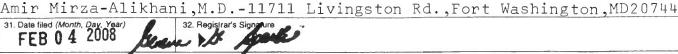
31. Date filed (Month, Day, Year) FEB 0 4 2008

32 egistrar's Signature

State Registrar

31. Date filed (Month, Day, Year) FFR 0 4 2008

29b. Signature and litle of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

0046046

29d. Date signed (Month, Day, Year)

		ľ	For State	State of Ma	ryland /		artment of H		d Mental H		U8	04852					
	Physici	an	1. Decedent's Name (First, Middle,		DALE		imeate or i		2. Date of D Februa		20\08	3. Time of Death					
	/Medic Examir	al	RICHARD  4a. Facility Name (If not institution, g  ALFRED HOUSE -		DALE	III	4b. City, Town, or ROCKV			4c. Count	y of Death	9:05 P M ERY					
	Funeral Director		7.1		(In yrs. last 89	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of B Min. (Month, I Jan.	irth Day, Year) 25 1919	Cou	olace (State or Foreign otry) cyland					
Maryland 2	Maryland	tor	Usual Residence of Decedent  10a. State 10b. County  Md. Mont	gomery	10c. City, To		cation Spring					10d. Inside City Limits 1 ☐ Yes 2 🕱 No					
	h with the	Funeral Director	10e. Street and Number 3701 Internation	onal Drive	-		10f. Zip Code	20906		10g. Citizen of Unit	What Cou	-					
	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "naturel; or items 23a or 28e-f show other traumatic event, the Wodcal Examirer must be notified at	ρ	11. Marital Status  1 Never Married 2 Name 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? d 1 □ Yes 2 💆 N If Yes, Give Year or Dates:			Vas Decedent of H i Yes, specify Cuba ☐ Yes 20 No	ispanic Origin In, Mexican, P Specify:	? (Specify Yes or Nuerto Rican, etc.)	No- 14. Ra Вla Speci	can Indian, etc. White						
	vithin 72 ho ne. hen "natur u Modleal	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5-		(Give life. l	lent's Usual Occupa kind of work done of OO NOT use retired	during most of	working	16b. Kind of E	Business/In	ndustry					
	12 should be filed within hand Mental Hygiene. 7 is marked other then "traumatic event, the Max	To Be Co	12 17. Father's Name (First, Middle, La Richard H. Lan			ACT	corney	18. Mother's	Name <i>(First, Midd</i> via Lir								
	1 and 2 shou Health and N Iem 27 is ma other traums		19a. Informant's Name/Relationship Phoebe T. Lanse		1	9b. Mailir 370	g Address (Street a	and Number o tional	Drive, S	ber, City or Town Silver S	o, State, Zij pring	, Md.20906					
Baltimore,	permit. Pages 1 s Department of He Importent: If Item any njury or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 1 ☐ Donation 5 ☐ Other (Spe	ocify)	ceme	etery, cren	sition (Name of natory or other plac Litan Cre		Date 2/5/08	20c. Location							
Fhysician /Medical Examiner	ate be executed  Wedical Examiner  The burnat-transit	oleted by Physician/Medical Examiner	by Physician/Medical	by Physician/Medical	Physician/Medicai	dicai	dicai	23a. Part1. Enter the disease, or coshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	H-Bar	consequent consequent consequent expression	ce of):	er the mode of dyin ecomonia and idia and ili	H. Bar Box 50: g, such as car	ber Funer 38, Layto diac or respiratory	arrest,		Approximate Interval Between Onset and Death  Week  Week  Week  years
Box 6	that the death certific ed by the attending pl detached for use as t					IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal de	ath 3	Ectopic pregnancy				ate of deliv	rery Day Year		
Records, P.O	requires seen sign hould be					Part II. Other significant condition	s contributing to death bu	t not resultin	ig in the ui	nderlying cause giv	en in Part I.	1 [ 24a. W	Yes 2 No	3 ☐ Pro	the cause of death?  bably 4  Unknown  opsy findings available ompletion of cause of		
Division of Vital Re	Jing Physiclen:  After this certifice funeral director, p	Certification: To Be Com	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investiga  3 Suicide 6 Could no determin	t be Diago of Inju	Year) 28	Outpatien b. Time of Injury	28c. Injun Worl M 1	er: 4 ☐ Nursi	pei 1 Yes  Death (Check onlying Home 5 Re 28d. Describ	rformed? 2 No / one) sidence 6 No e how injury occu	death? 1 Yes ther (Speci	Asst.					
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Co		Physician: To the best of caminer: On the basis of and manner sta	examination												
)	To th within To th compi		29b. Signature and title of certifier	Morrison	un D		29c. Licens			29d. Date sign							
1	10		30. Name and address of person w Bennett Mornis	no completed cause of de	lucy-	la) (Type,	Print) Ly Sprin	g Roas	l, Olney,	Marylan	1, 2	0832					

31. Date filed (Month, Day, Year) FEB 0 6 2008 Registrar DHMH 17 Rev 1/2001

State

32. Pojistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) ່ 30, 2008 **Physician** 10:07 aM January Randolph Linkous Otis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cecil Union Hospital of Cecil County Elkton Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1⊠ M 2□ Virginia 13,1926 West Dec. 235-36-7946 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Port Deposit Director Marvland Cecil 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21904 U.S.A. 148 Nantuckett Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No altimore, Maryland 21215-0036 Specify Specify: White 2 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a Decedent's Usual Occupation d 2 should be filed within 72 ho th and Mental Hygiene. 7 Is marked other than "natur. 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) General Motors Elementary/Secondary (0-12) College (1-4or 5+) Wilmington, Delaware Assembly Line Employee Ten Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental Nettie Dell Minnie Elbert Lee Linkous traumatic 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 21904 148 Nantuckett Drive, Port Deposit, Maryland permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. Zola Gaynelle Linkous (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Colora, Maryland 02/02/08 West Nottingham Cemetery 4 Donation 5 Other (Specify) 21. Signa re of Funeral Service Licensee Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903**-**0766 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Prostate ances **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): O. Box 68760, physician s the burial Physician/Medical as attending for use as IF FFMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) detached the 9 Unknown 9 Unknown ģ Division or Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an autopsy Jas 1□ Yes certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: Hospital 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient Certification: To After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 27. Manner of Death 5 ☐ Pending investigation Natural Natural 1 ☐ Yes 2 ☐ No death. 2☐ Accident ours after death. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide within 24 hours a To the Funeral I 1 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only onel 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie -0054086 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STIVA Maryland 21921 Jamil Khatri, M.D., 111 West High Street, Suite 104, Elkton, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

1 2008

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08-00554	
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Randy Ray Loudermilk

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland / Departr	nent of He	alth and N	Лental Нус	giene

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,,,a, , ,a,		For State  Certificate of Death Registrar	Reg.		0 0400
Physicia edical Exami	an/	1. Decedent's Name (First, Middle,Last)	Date of Death Month Da anuary 19, 1	ay Year 2008	3. Time of Death 2356 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 202 Pulaski Highway Elkton		4c. County of Death Cecil	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8		1 -	hplace (State or Foreign
Director		212-80-6664 1XM 2F 39 Yrs. Months Days Hours Min. 6	01/13/19	164	anitry) WV
w any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits  1 Yes 2 No
uryland 3a-f sho at once.	Director	MD Cecil EIKton  10e. Street and Number 10f. Zip Code	10g.	Citizen of What Cour	
vith the Maryland s 23a or 28a-f show a		6F Glen Creek Circle 21921		USA	
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Ric	fy Yes or No- an, etc.)	White, etc.	can Indian, Black,
rs after oural", o	ğ	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of works)	done 1	Specify: W	hite
)36 thin 72 houre. te. than "nathedical Exa	leted	Elementary/Secondary (0-12) College (1-4 or 5+)  Concrete Finisher		Constru	
21215-0036 uld be filed within 72 Mental Hygiene. marked other than 'c event, the Medical	Completed	17. Father's Name (First, Middle, Last) 18. Mother's Name (Fi		iden Surname)	<u> </u>
21215-( uld be filed v Mental Hygi marked oth	Be	Harold Lee Loudermilk Frances  19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rura		Mc Kinz	
b, MD 21215-0036 and 2 should be filed within 72 tenth and Mental Brigation from 27 is marked other than "traumatic event, the Medical.	To	Ralph Loudermilk /Uncle P.O. Box 404 Ris	sing Sc	on MD	21911
Baltimore, MD 21215-003 permit Pages I and 2 should be filed with Department of Health and Mental Higde with Important: If item 27 is marked other thingury or other traumatic event, the Med		1 Burial 2 Cremation 3 Removal from State crematory or other place)		20c. Location - City or Newar	
Baltimore, permit. Pages I an Department of Hee Important: If ite		21. Signature of Funeral Service Liotnisee  22. Name and Address of Eacility  Strang + Feeley Faculty  4 Donation 5 Other Specify:  22. Name and Address of Eacility  Strang + Feeley Faculty  4 35 Churchman	mily 1	Funeral Ho	
Physician		Z3a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re	spiratory arrest	NEWARK T	Approximate Interval
MiiI 'xaminer		failure. List only one cause on each line.  Immediate Cause (Final disease a. Hanging			Between Onset and Death
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.			
	Examiner	if any, leading to immediate cause. Enter Underlying Cause			
ecuted and transit		events resulting in death) Last  Due to (or as a consequence of):  d.			_
ā æ .	Medical	UNPENDED AMENDED		20d Date of deliver	
ox 68760, eath certificate be ex attending physician for use as the burial		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy	y	23d. Date of deliver Month	y Day Year
Box 687 e death certific the attending p	Physician/	1 Yes 2 No 9 Unknown g Unknown			
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of Vital Records, g Physician: The law require after this certificate has been si neral director, page 2 should b	Comp		perform 1 <b>V</b> Yes 2		es 2 No
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other; Nursing Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA		esidence 6 🗸 Othe	er: Scene
of V ling Phy. After thi funeral d	n: To	27. Manner of Death  28a. Date of Injury  28b. Time of Injury  28c. Injury at Work?  28 St. Methods  28c. Injury at Work?		w injury occurred ged self	
Division tal or Attendir rs after death. all Director: A led in by the fu	Certification:	2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc. 28			ural Route Number, City
Divi	Certil	4 Homicide determined (Specify) Vacant Lot		ghway, Elkton, Md.	
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certificate that bies deedsh.  The Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as it	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and du one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.	ie to the cause ne time, date ar	(s) and manner as sta	he cause(s)
T × E	Me	29b. Signature and title of certifier  29c. License number  O.C.M.E.	- 1	29d. Date signed (Manuary 20, 200	_
		30. Name and address of person who completed cause of death (Item 23a)			-
		Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21	201		
S Regis	tate trar	31. Date filed (Host Day, Year) 2008 33 Registrar's Signature		OCME	

			1 - For Stata Registrar		of Marylar				lealth a Death			Rag. No.	008	048		
	Physici	ian	Decedent's Name (First, Middle)								2. Date of Dea Month	Day	Year	3. Time of	Death ) a <sub>M</sub>	
	/Medi	cal	Geane L  4a. Facility Name (If not institution,	illian Leil			4h Cih	. Tours o	r Location	of Death	February		2008 ounty of Death		CT (A)	
	Examir	ner	Maplewood Park		intoer)		40. 00		ethesd			40.0		omery		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	. last birthday)	) If Under	er 1 Year	If Under Hours		8. Date of Birt (Month, Da)	h V Year)		place (State or intry)	r Foreign	
186 h	Director		577-18-3725	1 ☐ M 2 🖾 F	89	Yrs.	IV)OH(H)	Days	riodis	IVIII.	May 29,			ict of Co		
200	* *		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	ocation							10d. Inside Cit	y Limits	
N S	e be	ţō	Maryland Mont	gomery				19	ethesd	а				1 X Yes	2 🗌 No	
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4	23a c	aiD	9707 Old George	own Road					20814				U.S.A.			
200	To Tie	Funeral Director	11. Marital Status	Armed F		J.S. 13.	Was Dec If Yes, sp	edent of H	lispanic Ori an, Mexicar	igin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)	. 14	. Race - Ameri Black, White			
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21215-0036	atura cal E	ted	15. Decedent	s Education		16a. Dece	dent's Us	ual Occup	ation			16b. Kind	b. Kind of Business/Industry			
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<u>ב</u>	and Mental	70	Meyer Rosenbl			19h Maili	ing Addres	s (Streat	and Numb	ar or Bur	Ida Davi al Route Numbe		Town State Zi	n Code)		
Z S	Definition of Health and Department of Health and Important; if item 27 is nany injury or other traum once.		Elaine Davis - D								Penthous				3154 FL	
Je,			20a. Method of Disposition			Place of Dispo cemetery, cre				1110,	Date	20c. Loca	ation - City or T	own, State		
Baltimore,	nent c int; if iry or		1 ⊠ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State	rden of			1	02/05	5/2008	Clark	sburg, Ma	aryland		
	Departn Imports any inju		21. Signature of Funeral Service	icensee	.00				ss of Facili		ome, Inc.					
00 8	RQE # 9		23a. Part1. Enter the disease or	Warn	ell	1	1800 I	New Ha	mpshir	e Ave	nue, Silv	er Spr	ing, Mar	yland 20	904	
acuted	hysician physician and wasician and the purial-transit	Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and learning to the conditions of the cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. Due to		uence of):	ON	///	7					Onset and C	leath	
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	ng ph		IF FEMALE:													
P.O. Box 6	igned by the attending be detached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	utcome of pregn birth 2 Fet mant at time of on nown	al déath 3[	□Ectopic □ Other (s		/			23d. Date of delivery Month Day Year			'ear		
	been signed I should be det	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I,								23e. Did tobacco use contribute to the cause of death?  1  Yes 2 Tho 3 Probably 4 Unknown					
۾ ڪ	ate ha	Completed											24b. Were aut prior to co death? 1 \( \subseteq \text{Yes}	opsy findings a completion of ca		
/ita	certificate rector, pag	Be	25. Was case referre medical examiner?	ili				Lou		of Deat	h (Check only o	ne)				
Of Physic	this o	2	1 Yes 2 No			ER/Outpatie			41.9/110		me 5 Resid			ıfy)		
vision of Vita	h. After funer	tion	1 vatural 5 Pending 2 Accident investig		of Injury oth, Day Year)	28b. Time of Injury	M	28c. Injur Wor	yan k? Yes 2 🗍		28d. Describe h	iow injury	occurred			
5 6	i ji ji	Certification:	3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Ptac	e of Injury - At t ding, etc. (Speci	nome, farm, st	reet, facto				28I. Location (S City or Tox		Number or Rui	ral Route Numi	ber,	
The Hospital	n 24 hour he Funer sletely fills	edical	29a. Certifier 1 Cartifying (Check only one) 1 Madical E	Physician: To the xaminer: On the and mai	e best of my kn basis of examin nner stated.	owledge, deat ation and/or in	th occurre ivestigation	d at the tir in, in my o	ne, date ar pinion, dea	nd place, ith occur	and due to the red at the time,	cause(s) a date and p	nd manner as place, and due	stated. to the cause(s	)	
Ţ	To the	Σ	29b. Signature and title of certifier						e number				signed (Month			
	ID		1000	Ce	fer	10		02	62	59		2	141	1200	28	
	10		30. Name and address of person was AVA A KAV	FME	'MD	m 23a) (Type,	. Print)	wi	500	N	51N -	3VE	,30,	THES	11,	
	Sta Regista		31. Date filed (Month, Day, Year)	2008	Registrar's Sign	S. A	anti-	9								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Nathanie /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner If Under 1 Year | If Under 2 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) Security Number 6. Sex Days **Funeral** Months Hours 1MM 2□F Feb. 25,1941 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location after death with the Maryland 10a. State 28a-f show 1 TRYes 2 □ No Department of Health and Mental Hygiene. Important; If Item 27 Is marked other than "natural", or Items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified. Director bridge 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1613 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 12 No Maryland 21215-0036 Black þ 3 ☐ Widowed 4 ☐ Divorced 72 hours Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) I Hygiene. filed within Elementary/Secondary (0-12) College (1-4or 5+) rocessing Worker 12 Line -ond 17. Father's Name (First, Middle, Last) ith and Mental h 1 and 2 should be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) .. Pages 1 and ment of Health an 27 ls Cambridge, MD. 21613 Rachel 20c. Location - City of Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 08 Cambridge, Maryland Cordtown Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility

Henry Funeral Home, RA.

Henry Funeral Home, RA.

Stown Shington St. Camb

Stock, or heart failure. List only one cause on each line. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MD.21613 Approximate Interval Between Onset and Death Immediate Cause (Final Squamous months **Physician** disease or condition resulting in death) /Medical (or as a consequence of): Examiner weck aaite vena Caquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed and burial-tran Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as IF FEMALE asn 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death Month Day Year ō in the past 12 months? 1 ☐ Yes 2 XNo P.O. the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown anemia Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page 2 s performe 2 No 1∐ Yes this certificate 26. Place of Death (Check only one) director, 25. Was case referred to medical examiner? Be Other: 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 [X]Inpatient 2 ER/Outpatient 2**\_X**No P 1 TYes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of funeral Injury at Work? 27. Manner of Death Certification: After Injury 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide determined the Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Mont

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra/Amend#26.PerPhys.PGC2-5-08cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 7 2008 William E. Lytle 2155AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Marlboro Prince George's 406 Ashaway Lane If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 ☑ M 2 ☐ F 74 289-28-6687 Oct. 12, 1933 Ohio Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Director OH Clark Springfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 803 East Cecil 45503 Funeral USA 14. Race 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1⊠Yes 2□No 1957— If Yes, Give Year or Dates: 1958 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Trucking Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul Lytle Mae Embry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 406 Ashaway Lane Upper Marlboro, MD 20774 Paul G. Lytle/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State Dayton Nat'l Cemetery 2/8/2008 4 □ Donation 5 □ Other (Specify) Dayton, OH 21. Signature of Funeral Service Licenses 22. Name and Address of Facility M01442 Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 23a. Part. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER bincreas Due to (or as a nsequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Whiknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performe Yes 2 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home Appliestence 6 MOther (Specify) Scn's Home 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

23a

or items

"natural",

Pages 1 and 2 should be filed within : nent of Health and Mental Hygiene. nt: If Item 27 Is marked other than "

Department of Health ar important: If Item 27 is any injury or other trau

the Medical Examiner must

death with the Maryland 3a or 28a-f show it be notified at

72 hours after

Baltimore, Maryland 21215-0036

page

P.O. Box 68760.

that the death certificate be executed attending physician and for use as the burial-tran signed by the a has certificate After this funeral

Physician/Medical þ Completed Be မ

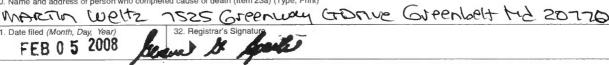
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DHMH 17 Rev 1/2001

Division or Vital Records, Certification: ospital or Attending I hours after death. Director. filled in by hin 24 hours at the Funeral D Hospital Medical

31. Date filed (Month, Day, Year) FEB 0 5 2008

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Matural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

5 Pending investigation

6 Could not be determined

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

153743

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 28, 2008 Mark January Laupert 3:02 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland 16519 Oak Crest Lane If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F 47 212-88-4440 Director 09/24/1960 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Cumberland Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16519 Oak Crest Lane 21502 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. MYes 2□No 1978-Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Year or Dates: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing 12 Machinist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Brigitte Louise Edward Walter Lauper ္က 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina Hamm / Sister 16519 Oak Court Lane, Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cumberland Crematory 1/29/2008 Cumberland, MD 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility Adams Family Funeral Home, P.A. of Funeral Service License 21. Sidnature 23a. Part1. Enlewhe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or had failure. List only one ceuse on each line. 21502 404 Decatur Street, Cumberland, MD Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** FARS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of) attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was en 1□ Yes To the Hospital or Attending Physician: Be ( funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No s after death. investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0054004 January 28, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1221 National Highway, LaVale, MD Shiv C. Khanna, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

ORIGINAL.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) JANUARY 27, 2008 Physician 0545 MARTHA LASHLEY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CUMBERLAND ALLEGANY WMHS-Memorial Campus If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days Min January 25, 1924 West Virginia 84 218-12-5975 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at 1 ☐ Yes 2 No Directo Frostburg Allegany Maryland 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 16511 Lashley Drive a or U.S.A 21532permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s any injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Givef Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Delphia Johnson David Varner ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21532-Maryland daughter Frostburg 16509 Lashley Road, S.W. Sandra Imes 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) January 30, 2008 Cumberland Maryland Sunset Memorial Park 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumon **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 🔀 No 9 I Inknown sate has been signed by page 2 should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 🔽 Inpatient 2 1 ☐ Yes 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier JANUARY 27, 2008

200

State Registrar 31. Date filed (Month, Day, Year)

JAN 2 9 701



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

o Ab Alackie

Qamar

umberland, Maryland 21502

			For State Registrar	State of Maryland	-	artment of H rtificate of I			iene 2	008	048	60
		73	Decedent's Name (First, Middle, Last)					2. Date of Death	h		3. Time of D	eath
.187	Physici	_	Eugene Raymond 1	Lynch, III				Month Februar	v 1. 2	Year 2008	3:17a	М
	/Medio	iles me	4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Deat		-	ty of Death		
	Examin	iei	Montgomery Hospice			Roc	kville		Mor	ntgom	erv	
	Funeral		5. Social Security Number 6. Sex		ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birth	nplace (State or I	Foreign
	Director		407-86-3104	M 2□F 50	Yrs.	Months Days	Hours Min.	(Month, Day, April 2			untry) talv	
15/4	Sign and the second		Usual Residence of Decedent									
	/land		10a. State 10b. County	10c. City	, Town or Lo	ocation					10d. Inside City	
	Mar fied	to	Maryland Mor	ntgomery		Silver Sr	oring				1 □ Yes 2	∑ No
	r 28a	Director	10e. Street and Number	<u> </u>		10f. Zip Code		10	0g. Citizen o	f What Co	untry?	
	3a o		9206 16th Stree	et		20910	)		USA			
	72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examiner must be notified at	Funeral	11. Marital Status	Was Decedent Ever in U.     Armed Forces?	S. 13.	Was Decedent of H	lispanic Origin? (S	Specify Yes or No-		ace - Amei	rican Indian,	
(0	or ite		1 ☐ Never Married 2 【X Married	1 Yes 25 No		1 ☐ Yes 23 ☐ No	Specify:	to racan, etc.,				
5-0036	urs a al", c Exar	b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		IL Yes ALINO	эреспу.		Spec	ify.whi	Le	
9	2 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	dent's Usual Occup	ation during most of wo		16b. Kind of	Business/I	industry	
21	within 7 iene. than "r the Med	pje	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)	9				
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p	be filed within 72 ho ntal Hygiene. od other than "natur event, the Medical.	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, M	Aaiden Surn	ame)		
a	ld by Jents rked	10E	Eugene Raymond Lyr	nch, Jr.			Elena [	DelGaudio				
Maryland	es 1 and 2 should be filed w of Health and Mental Hygier f item 27 is marked other th or other traumatic event, the	Г	19a. Informant's Name/Relationship (Type		1	ng Address (Street			-			
Ž	nd 2 alth a 27 is		Mary Ellen Lynch,	/ Wife	92	06 16th S	Street, S	Silver Sp	ring,	MD 2	0910	
Baltimore,	Pages 1 and 2 ment of Health a ant: If item 27 is ury or other tra		20a, Method of Disposition		lace of Dispo	osition (Name of matory or other place	ce) Fel	Date 5,	20c. Location	n - City or	Town, State	
100	age ent o it: If		XX Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		Heaven Ce	1 - 4-1		Silvar	Snr	ing, Mar	wlan
=	- P P F		21. Signature of Funeral Service License			2. Name and Addre		2000	DIIAGI	. DPI.	ing, nai	утан
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			23a. Part1. Ent. the disease, or complishock, or heart failure. List only or Immediate Cause (Final	e cause on each line.		,	3,				Onset and De	een eath
١.	Physician		disease or condition resulting in death)	Bladder Can						-		
1	/Medical Examiner		Due to (or as a consequence of):									
		<u>.</u>	Sequentially list conditions,	Due to (or as a consequence	uence of):					-		
	pe tis	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	derice oi).							
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence	nence of).							
8760,	e ex	Ê										
87(	ate b	dical										
9	ing p	Mec	IF FEMALE:							,		
Box	eath certific attending pl for use as t	Physician/Med	23b. Was decedent pregnant	3c. If yes, outcome pf pregna 1☐Live birth 2☐Feta	ancy I death 3[	□Ectopic pregnanc	у			Date of del Month		ear
	dea te att	ic.	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time of d 9□Unknown	eath 5[	Other (specify)				IVIOITUT	Duy	Juli
P.0	that the de ned by the a detached	چ	9 Unknown									
	res tha signed be det	by F	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the u	underlying cause giv	en in Part I.				the cause of de	
Ď	w require been signature							1 TY	es 2∐No	3	robably 4 🖭 ur	nknown
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Be	he la e has	Ĕ						autops	med?	death?		use oi
a			25. Was case referred to medical				26 Place of De	1  Yes eath <i>Check onl on</i>	2 🔀 No	1 🗆 1 es	20110	
$\equiv$	Physician: The law rithis certificate has be ral director, page 2 s	Be C	examiner?	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatio	ent 3 DOA Oth	305.	Home 5□Reside		Other (Co-	cify) Hosp	pice
ō	Phys r this ral dii	2 :	27. Manner of Death	28a. Date of Injury	28b. Time		7 Littlianing	28d. Describe ho			icity) 110 E	
n	ding F	io	X⊠Natural 5 ☐ Pending	(Month, Day Year)	Injury		rƙ? ]Yes 2⊟No		a. Become non injury cocurred			
-=	Attending r death. ector; Afte by the fune	cat	3 Suicide 6 Could not be	28e. Place of injury - At he	ome farm st			28f Location (S	treet and Nu	mber or Ri	ural Route Numb	er.
(J)	after of Direct of in by	ŧ	4 ☐ Hornicide determined	building, etc. (Specif	y)	ileeli, faetoly, ellee		City or Town				,
ivis		al Certification:	Contifice 11 Contifuing Day	leian. To the heet of my kno	wlodgo dea	th occurred at the ti	ime date and nlad	ne and due to the o	auso(s) and	manner a	s stated	
Division or Vital	urs a urs a eral [			sician: To the best of my kno ner: On the basis of examina	ation and/or i	nvestigation, in my	opinion, death oc	curred at the time, o	date and pla	ce, and du	e to the cause(s)	
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Divis	the Hospital hin 24 hours a the Funeral I npletely filled		(Check only 2 Medical Exami	and manner stated.		200 Linear	se number		Od Data de	ned /Man		
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Divis	To the Hospital within 24 hours a To the Funeral I completely filled		29b. Signature and title of certifier  29b. Name and address of person who co	and manner enated.		, Print)	d6461	L5	Febr	ruary	th, Day, Year) 1, 2008	3
Divis	To the Hospital within 24 hours a To the Funeral I completely filled		(Check of V) 2 ☐ Medical Examilation (Check of	and manner enated.	01 Mun		d6461	L5	Febr	ruary	th, Day, Year) 1, 2008	3

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2008

			1 - For State Registrar	of Marylan	-		of Health of Deatl		-	giene Reg. No	n a	01.852
	Physici		1. Decedent's Name (First, Middle, Last)  Malka Lipman						2. Date of De	The Park	08°	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and Shady Grove Adventist H				wn, or Location	n of Death		4c. County Mont		ry
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 1	7. Age (In yrs. 81	last birthday) Yrs.	If Under 1 \ Months D	Year If Unde Days Hours	er 24 Hrs. Min.	8. Date of Bir 4/10/1	th (26ar) 9 2 6	9. Birth	place (State or Foreign oftry) and
	e Maryland a-f show iffied at	ctor	Usual Residence of Decedent		, Town or Lo					-		10d. Inside City Limits 1 ☐Yes 2 ☐ No
	th with the 23a or 28 ist be no	Funeral Director	10e. Street and Number 1235 Potomac Valley Roa	ıd		10f. Zip Co				10g. Citizen of V United S		•
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funer	1 Never Married 2 Married 1 Yes.	ecedent Ever in U. Forces? s 2 D No Give X Dates:	1	Was Deceden If Yes, specify 1 ☐ Yes 2			ecify Yes or No Rican, etc.)	Blac	e-Amerik, White,	
Baltimore, Maryland 21215-0036	d within 72 ho giene. Ir than "natur the Medical	Completed by	15. Decedent's Education (Specify only highest grade complete  Elementary/Secondary (0-12)  College	d) e (1-4or 5+)	(Give	DO NOT use r	done during ma	ost of worki	ing	16b. Kind of Bu		dustry
land;	uld be filed Mental Hyg rked othe	To Be C	17. Father's Name (First, Middle, Last) Wolf Silberstein				I .		(First, Middle Schmukl	, Maiden Surnam .erska	е)	
, Mary	and 2 sho salth and 1 127 is ma er trauma		19a. Informant's Name/Relationship (Type. Print)  Ruth Kummings - Daught	er		,				er, City or Town, ington I		,
imore	Pages 1 ament of He ant: If Item ury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	m State C	emetery, crei	sition (Name of matory or othe [emoria	of erplace) 1 Park		) 08	20c. Location - Corpus	•	own, State
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licenses	2						ıl Chapel ville MD		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause o immediate Cause (Final disease or condition resulting in death)  Due	n each line.	NEL	er the mode o		as cardiac o	or respiratory a	arrest,		Approximate Interval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	to (or as a consequence to (or as a consequence								
Box 6	Attending Physician: The law requires that the death certificate releath. ector: After this certificate has been signed by the attending physisy the funeral director, page 2 should be detached for use as the	Physician/Medical	in the nast 12 months?	outcome pf pregna e birth 2 Feta egnant at time of d known	Ideath 3□	⊒Ectopic pregi □ Other <i>(speci</i>				23d. Dat		ery Day Year
rds, P	quires than a signed to the details and be detailed to the details and the details and the details are the signed to the signed	þ	Part II. Other significant conditions contributing to	death but not resu	ulting in the u	nderlying caus	se given in Par	t I.	23e. Did 1	.0		he cause of death? bably 4 Unknown
al Reco	: The law requir cate has been s ; page 2 should	Completed							24a. Was auto perfo 1□ Yes	psy prmed?	Vere auto prior to co leath? □Yes	opsy findings available ompletion of cause of
or Vit	Physician this certifi al director	To Be		Inpatient 2	ER/Outpatier		Other: 4 🗆 I	Nursing Ho		idence 6 □Oth		fy)
Division or Vital Records, P.O.	To the Hospital or Attending Physician: The lawithin 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	1 Natural 5 ☐ Pending (M 2 ☐ Accident investigation	onth, Day Year) ace of injury - At ho	Injury	М	Injury at Work? 1 ☐ Yes 2 [ ffice	□No	28f. Location (	how injury occurr Street and Numb wn, State)		al Route Number,
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	Medical Ce	29a. Certifier 1 Certifying Physician: To (Check only one) 2 Medical Examiner: On the	e basis of examina	wledge, deat tion and/or in	h occurred at t vestigation, in	the time, date my opinion, d	and place, leath occur	and due to the	e cause(s) and ma , date and place,	nner as	stated. to the cause(s)
)	To the To the Comple	Mec	29b. Signature and title of certifier	anner stated.	20		icense numbe		9	29d. Date signed	(Month	
	U		30. Name and address of person who completed control of the truing Bao 9715 Medica	ause of death (Item	23a) (Type,		ille M	D 208	50			-
	Sta Registr		31. Date filed (Month, Day, Year) 32 FFR 0 4 2008	egistrar's Signa	ture	edi						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear **Physician** 2:50 P 31, 2008 BERTHA LIEBER JANUARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SUBURBAN HOSPITAL MONTGOMERY BETHESDA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/01/1915 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🖺 F 189-10-9632 92 PA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 X Yes 2 ☐ No Director MD MONTGOMERY SILVER SPRING 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or filed within 72 hours after death with ms 23a ( must b 3322 CHISWICK COURT #3E 20906 USA Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or Items 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: WHITE Completed by 3 → Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) 12 SALESPERSON RETAIL 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 is marked other any ijlury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be DVORAH "UNKNOWN" PENYA KRAVITZ P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DOLORES BERGSTEIN - DAUGHTER 3526 CHISWICK COURT, SILVER SPRING, MARYLAND 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State JUDEAN MEMORIAL GDNS 02/03/2008 4☐Donation 5 ☐ Other (Specify) OLNEY, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 Part V Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Renal **Physician** cute disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Si Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner ai lune c Hypoxia Dictor burial-trar Due to (or as a consequence nding physician a the death certificate be eval IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Completed by 1 | Yes 2 | No 3 | Probably 4 Nunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2☑ No 24a. Was an autopsy perform certificate 2/X No Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) > No 1 Hopatient 2 ER/Outpatient 3 DOA P 1 ☐ Yes or this 27. Manner of Death 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After (Month, Day Year) Division To the Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatu 15 30. Name and address of person who come leted cause of death (Item 23a) (Type, Print) SIMA NOURANI ZENUZ, MD 8600 OLD GEORGETOWN ROAD, BETHESDA, MARYLAND 31. Date filed (Month, Day, Year) egistrar's Signature State FEB 04 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Rea, No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 30 200 Lecompte George Malche /Medical 4b. City, Town, or Location of Death 4e. Fecility Name (If not institution, give street and number) 4c County of Death Examiner Coastal Hospice at icomico Dalisbur If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, NOV. 7 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1**™**M 2□F 62 2729 214-46-272 Usual Residence of Decedent Director NOVE Maryland with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f ahow traumatic event, the Medical Exactings must be notified at 1 Yes 2 No Cambridg Director Dorchester 10f Zin Cod 10g, Citizen of What Country? 10e Street and Number 70 or items 23a 30 Rose Mount Avenue 161 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Marned 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Yes 2 No Maryland 21215-0036 Specify ۵ Specify: Black 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry reges 1 and 2 should be filed within 72 ment of Health and Montal Hygiene.
nti: If them 27 ie marked other than "nat ry or other trainmetic. Elementary/Secondary (0-12) College (1-4or 5+) Rehabilitation Center 5+ Educational Counselor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nichols Nalter Ennels ou ise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walderf, Maryland 20602.
Date 200. Location City or Town, State Bernard Court 681-Doral Jones Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 108 Department Important: If any injury or once. Petersburg Cometery \* 4 □ Donation 5 □ Other (Specify) Hurlock, Maryland 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate

Approximate Immediate Cause (Final disease or condition resulting in death) END STAGE ACQUIRED IMMUNE DEFFICIENCY SYNDROWE **Physician** /Medical Due to (or as a consequence of) **Examiner** RANAL HPONIC PAILURG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical use as the IF FEMALE If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ of Vital Records, 1 Tyes 2 No 3 Probably 4 Unknown Completed been 24a. Was an autopsy performed? 1 ☐ Yes Z ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ☐ Ro certificate or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 2 No this s after death.

I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1-Natural
2 Accident Division 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00058410

State

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

HOSPICE

LO BOX 1933 SALIS BUNGAD

ess of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

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WARK

Husten

31. Date filed (Month, Dar FEB 0 5

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** DOLORES McKENNA FEBRUARY 2008 18:15 F. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY MONTGOMERY GENERAL HOSPITAL OLNEY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 📉 F 106-05-7339 93 Sept. Director 19 1914 New York Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Md. Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20853 14519 Manor Park Drive death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 9 3 ₩idowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Board of Education 0 Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick Herr Mary Bielmann ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7317 Rosewood Manor Lane, Gaithersburg, Md. 20882 Mark McKenna / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 SCremation 3 ☐ Removal from State 2/6/08 Alexandria, Va. 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home Xon Say 20882 Box 5038, Laytonsville, Md. P. O. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ritation disease or condition resulting in death) /Medical (or as a consequence of) Examiner Equentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed and burial-trar Due to or as a consequence Box 68760. attending physician Physician/Medical as the nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) P.O. ed by the 9∏Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 2/ No 3 Probably 4 Unknown 1 Tes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2□ No 1 🗆 Yes Division or Vital Physiclan: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death al or Attending Pl s after death. al Director: After the 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and ince Philip Dr. 31. Date filed (Month. State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Deckert Carter Reese 01:53 AM MOOR February 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7822 Old Farm Lane Ellicott City Howard 8. Date of Birth (Month, Day, Feb 12, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** <sup>Year)</sup> 2003 Days Months Hours **15** M 2 □ F Maryland Vre 219 65 4373 4 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r 28a-f show notified at 1 Tyes 2 No Director MD Ellicott City Howard 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code ms 23a or 7 21043 United States 7822 Old Farm Lane Funeral 14. Race - American Indian, r than "natural", or items the Medical Examiner me 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: Never Married 2 ☐ Married 1 ☐ Yes 2 █**X**No Specify. Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other traumatic event, t once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John R. Moore Holly K. Deckert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7822 Old Farm Lane Ellicott City, MD 21043 John R. Moore/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State Ardent Crematory 2-6-2008 Hanover, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 ale 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Neuroblastoma **Physician** Eight month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Urderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trar Due to (or as a consequence of): physician Physician/Medical the as signed by the attending the detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ cate has been sig , page 2 should b 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natura 5 Pending investigation Injury

requires that the death certificate be executed P.O. Box 68760, Division or Vital Records, funeral After

death with the Maryland

filed within 72 hours after

and 2 should be

Pages 1

3altimore, Maryland 21215-0036

e Hospital or Attending P 24 hours after death. e Funeral Director: After t filled in by 24 hours a within 2

EG.

State Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

6 Could not be determined

2 Accident 3 ☐ Suicide

4 Homicide

(Check only one)

FEBNAY, 05, 2008

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

CMSC-800; 600 WORTH Wolfe street; backmore wary kind 21287

31. Date filed (Month,



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Z U U 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Philip Joseph Monte February 1, 2008 6:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) New York 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Director 066-12-8213 89 Jan 15, 1919 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Maryland Montgomery Derwood 1 TYes 2 No. Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 5601 Silo Hill Court 20855 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married ⊠Yes 2□No World fYes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 Widowed 4 Divorced Year or Dates: War II White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Restaurant and Elementary/Secondary (0-12) College (1-4or 5+) Motel 5+ Businessman permit. Pages 1 and 2 should be fili Department of Health and Mental Hi Important: If Item 27 Is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Stephen Monte Josephine D'Auria 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Josephine M. Piccone (Daughter) 5601 Silo Hill Court, Derwood, MD 20855 20b. Place of Disposition (Name of ALL Souls 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation February 4, al from State 4 Donation 5 Dother (Specify) emetery 2008 Germantown, Maryland ure of Fundral Service 22. Name and Address of Facility 21. Signa DeVol Funeral Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. lart1. Enter the disease, or complications that caused the death. So, ot enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Immedia s Cau e (Fin il disease or conditi n resulting in death) **Physician** /Medical Due to (or as a consequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760. the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 1☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2No 2 ER/Outpatient 3 DOA ဥ 1 Inpatient To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director; After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Mpnth, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Conta & Rocti, IIC, NO 20850 31. Date filed (Month, Day, Year) State FEB 0 5 2008 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of M	arylan			nt of He te of D		nd Me	_	giene Reg. No.	2008	04870
	Physicia		Decedent's Name (First, Middle, Li     VIRGINIA	ast) L. MEAD	-					2	2. Date of De Month JAN			3. Time of Death  11:43 PM
	/Medic Examin		4a. Facility Name (If not institution, gi			R	4b. City	BETH	Location of E	Death		_	County of Deat	n
-ben's	Funeral Director		081-20-4540		ge (In yrs. 35	last birthday) Yrs.	If Unde Months	or 1 Year Days	If Under 24 Hours	Min.	B. Date of Bir (Month, Da Dec 17	th y, Year) , 1922	9. Birtl Co. New	nplace (State or Foreign untry) York
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D-0030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: I flem 27 is marked other than "hatural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1  Yes 2 If Yes, Give Year or Dates:	?			edent of His ecify Cubar 2⁄Q No	spanic Origir n, Mexican, I Specify:	n? (Spec Puerto R	ify Yes or No ican, etc.)		14. Race - Amer Black, White Specify: Ch:	e, etc.
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	/Medical Examiner		resulting in death)  Seguentially list conditions,	Due to (or as	a conseq	uence of):								
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ecords, r	equires that en signed b	by	Part II. Other significant conditions	contributing to death b	out not resi	ulting in the ur	nderlying	cause give	n in Part I.		23e. Did t	_	_	the cause of death?
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VII.	ician Sertifi ector	Be	25. Was case referred to medical examiner?	Hospital:				0#-		f Death (	Check only	one)		
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DIVISIO	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Certification:	2	be 280 Place of in	jury - At ho tc. <i>(Specif</i>	ome, farm, stre	M eet, facto		′es 2∏No		8f. Location ( City or To			ral Route Number,
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l	0		30. Name and address of person who	completed cause of	death (Item	n 23a) (Type,	Print)		240316 IONAL				CENTER	1008
			STEVEN P. ARMBRU			USN					20889-			
	Sta Registr		31. Date filed (Month, Day, Year)  FFR 0 5 2	32 Regist	rar's Signa	ture	ast s							

State of Maryland / Department of Health and Mental Hygiene 2 1 1 2

			For State Registrar	State	of Marylar	nd / Depa <i>Cei</i>	artment of F rtificate of	lealth ar <i>Death</i>	nd Mental	Hygiene		04871
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	/Medic		HELEN  4a. Facility Name (If not institution	n, give street and n		CCALL	4b. City, Town, o	r Location of !		RUARY	1 2008 County of Death	12:55 PM
			MANOR CARE NO. 5. Social Security Number	URSING HO	ME 7. Age (In yrs.	last hirthday)	LAR	GO If Under 24	Hrs. 8. Date of		PRINCE G	EORGE S
	uneral irector		253-40-9522	1 □ M 2 🔼 F	78	Yrs.	Months Days		Min. Monti Feb	h, Day, Year 12	Cou	RGIA
yland	at		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
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I C I C I C I C I C I C I C I C I C I C	item 27 is marked other, than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marr 3 ☑ Widowed 4 □ Divorced	Armed F	2 <mark>√</mark> No aive		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2☐XNo	lispanic Originan, Mexican, F	n? (Specify Yes of Puerto Rican, etc	or No-	14. Race - Ameri Black, White, Specify: B	
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Pages 1 trment of He	Important: If item 27 is any injury or other tra once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S	pecity)	n State	VERDAL	sition (Name of matory or other place E CREMATO	DRY 2/	Date /6/2008		ocation - City or T	
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Physician	er this certificate eral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date	of Injury	ER/Outpatien		er: 🕰 Nursi			6 □Other (Speci	fy)
or Attending	Director: After th in by the funeral	Certification:	1 XNatural 5 Pendin 2 Accident investig 3 Suicide 6 Could r 4 Homicide determ	ation 28e. Place	nth, Day Year) se of injury - At he ding, etc. (Specif	Injury ome, farm, stre fy)		k? Yes 2∐No	28f. Locati	on (Street a	nd Number or Run e)	al Route Number,
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To th within	To th	Me	29b. Signature and title of certifie	Mu	~	~	29c. Licens			29d. Da	ate signed (Month,	Day, Year)
	3)		30. Name and address of person RICHARD FELDMA				Print)	32261 HAM MA	RYLAND		RUARY 5	, 2008
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 6 2008	Keen 32.			ROLLD LIAN	, 111				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Clifford Benjamin Mowbray Jr. 2008 February 1 3:45 p. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Coastal Hospice at the Lake Wicomico Salisbury 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 DMM 2 □ F Days Hours Director 65 212-40-8578 March 31, 1942 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show traumatic event, the Medical Examiner must be notifled at Wicomico Delmar MD 1 ☐ Yes 2 No Director death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8811 Archid Drive 21875 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: white Completed by 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) construction 12 electrician n and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fact to the fact of Health and Mental Int: If item 27 is marked of Clifford Benjamin Mowbray Helen Havlick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8730 Tips Lane, Westover, MD 21871 Betty Jo Mowbray p.r. Injury or other permit. Pages 1 am Department of Heali Important: If item 2 any Injury or other once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/7/08 Woodlawn Mem. Park Easton, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LBURAL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ARTBR ORONARY Si quantially list roundings if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) attending physician Physician/Medical the ! IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 25. Was case referred to medical examiner? Be 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No 1 Dopatient 2 ER/Outpatient 3 DOA After this Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainteness as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760 Hospital or Attending Physician:

dubla

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GHUMM WARIS COASTAL HOSPICA

P.U BOX1773 Stris BURY WE 21802

29d. Date signed (Month, Day, Year)

FEB ( 31. Date filed (Month, 2008

(Check only one)

29b. Signature and title of certifier

29c. License number

D0058410

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February **Physician** Vear 03 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death zeneva Hospida 6. Sex 1 M 2 ☐ F If Under 1 Year Social Security Number Birthplace (State or Foreign Country) Funeral Days Hours 215-58-548 7,1953 Maryland Director NOV. 1 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Marel Hygiene.
Important: If time Z1 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Ves 2 No Funeral Director ambridge 10g. Citizen of What Country? 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimoré, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Taxicab Chauffeur Service [2] 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be I Green Mack therine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cambridge, Maryland 21613
ate | 20c. Location - City or Town, State Beulah Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethel Cemetery ignature of Funeral Service Licensee

22. Name and Address of Facility

Henry Fune Roi Home, P.A.

Siowashington Str. Cambri

shock, or heart failure. List only one cause on each line.

Address of Facility

Henry Fune Roi Home, P.A.

Siowashington Str. Cambri

shock, or heart failure. List only one cause on each line. 21. Signature of Funeral Service Licensee Immediate Cause (Final disease or condition resulting in death) 14 yper fersive ditech **Physician** Cordinoscola /Medical Due to (or as a consequence of): **Examiner** Alcord Lymic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown Q□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director; 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1047924 2-4-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar NOMAN

31. Date filed (Month, Day, Year)

THANKY

DHMH 17 Rev 1/2001

P.O. Box 68760,

Division or Vital Records,

MD

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Physicia Medical Examin	niner Vaughn Earl Martin									Date of Dea Month	h Day Y	'ear	3. Time of Death 0912 hrs
euicai Examin	iei	Vaughn Ear  4a. Facility Name (if not institution, g	Mar	tin		b. Citv. T	own, or Lo	ocation of E	Death	Month January 2	4, 2008 4c. Coun	v of Deat	
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any		Usual Residence of Decedent  10a. State 10b. County		Ino City	, Town or Locati	20							10d. Inside City Limits
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212 ould be Menta marke	To Be	19a. Informant's Name/Relationship	(Type, Print )		19b. Mailing	Address	(Street				nber, City or T	own. Stat	e. Zip Code)
MD d 2 sho lth and n 27 is		Kimberlyn Willia		ghter							MD 20		, , ,
more, MD 21215-0036 Pages I and 2 should be fited within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she rother traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition  1 Burial 2 X Cremation 3	Pomoval from		Place of Disposi crematory or oth	tion (Nam	e of ceme	etery,		Date	20c. Locatio	n - City o	r Town, State
Pages nent or		4 Donation 5 Other Specia	fy:	Le	e's Cre	mato				6, 20			on, MD
Baltimore, MD 21215-0036 pernit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "injury or other traumatic event, the Medical.	1	21 Sunature of Fun, ral a rvio, Lio	W All	1	W 55-N	ame and	Address o	of Facility	Stewa	art Fu	neral	Home	, Inc.
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/Medical	- 1	failure. List only one cause on	each line. <sub>a.</sub> Head Injuries				, ,			, , .			Between Onset and Death
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uted d ansit	<u> </u>	events resulting in death) Last	Due to (or as a co	onsequence (	or):								
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To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only one) 2 Medical Examin		examination :									
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10 (12)	1	30. Name and address of person who									,		
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DHMH 17 Rev 1/2001 OCME 2006

OCME

State of Maryland / Department of Health and Mental Hygien For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 3, 2008 **Physician** Olivia S. Mako February 8:15 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Riderwood Village-Forest Crossing Silver Spring Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 💢 F Pennsylvania 160-14-5422 88 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ral', or iteme 23a or 28e-f ehow Examiner must be notified at 1 ☐ Yes 2 X No Directo MD Prince George's Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3158 Gracefield Road #609 20904 USA r death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ∐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Š 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Ith and Mental It 27 is marked of r treumatic ever Pages 1 end 2 should be John Siegfried Johnson Olivia Kullin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 s Department of Health ar Importent: if item 27 is any injury or other treu William P. Mako/son 12 Persimmon Court Bethesda, MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory | 02/05/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatore of Funeral Service Licenses Golfnga Homes Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Multiple Myeloma /Medical Due to (or as a consequence of) Examiner b. Recurrent Pneumonia Sequentially list conditions, if any, leading to in interlate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Attending Physicien: The law requires that the death certificate be executed Atrial Fibrillation Due to (or as a consequence of) Box 68760, Physician/Medical ettending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) the o 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been si 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? s certificete hes b lirector, paga 2 s' 1 ☐ Yes 1 Yes 2 No 2 □**X**No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 1 ☐ Yes 2 ☐XNo Pis After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 🖾 latural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide To the Hospital or within 24 hours aft To the Funerel Di completely filled in 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ruthumana MD Dulen D59524 February 4, 2008

State Registrar

(B) (B)

31. Date filed (Month, Day, Year) FEB 0 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Loveen J. Puthumana, M.D. 3110 Gracefield Rd. Silver Spring, MD 20904 32. Pegistrar's Signature

Physician /Medical Examiner

Funeral Director

State of Maryland / Department of Health and Mental Hygiene   Respect   Certificate of Death   Respect   Certificate of Death   Respect   Certificate of Death   Respect   Certificate of Death   Respect   Certificate of Death   Respect   Certificate of Death   Respect   Certificate of Death   Respect   Certificate of Death   Respect   Certificate of Death   Respect   Certificate of Death   Respect   Certificate of Death   Respect   Certificate of Death   Respect   Certificate of Death   Respect   Respect   Certificate of Death   Respect   Respect   Certificate of Death   Respect	-	pe or Print in B					9	е.
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15. Decedering Education   (Specify vity) in planest agree completed   (16. Developments Usual Occupation   (16. Develop	••	If Yes, Give Year or Dates:	1	☐ Yes 21X No	Specify:		Specify:	White
Emeratory Geometry (0-12)   College (1-4or 5+)   Trainman   Railroad	15. Decedent's Educa	tion	16a. Decede	ent's Usual Occup	ation		16b. Kind of Busin	
17. Father's Name (First, Middle, Last) Andy Thomas Miller Daisy Fearl 19s. Informatis Name/Felationship (Type, Print) James W. Miller / son 140.03 Cedarwood Drive, SW, Cumberland, MD 21502 20s. Method of Disposition 18 Darial 2 Micromatis of Chip of Town, State 2p Code) 140.03 Cedarwood Drive, SW, Cumberland, MD 21502 20s. Method of Disposition 18 Darial 2 Micromatis of Chip of Town, State 2p Code) 140.03 Cedarwood Drive, SW, Cumberland, MD 21502 20s. Method of Disposition 18 Darial 2 Micromatis of Chip of Town, State 2p Code) 140.03 Cedarwood Drive, SW, Cumberland, MD 21502 20s. Method of Disposition 18 Darial 2 Micromatis of Chip of David Comments of Chip of Town, State 2p Code) 19 Date (Comments of Chip of Town, State 2p Code) 19 Date (Comments of Chip of Town, State 2p Code) 19 Date (Comments of Chip of Town, State 2p Code) 21 Shaperfeeld (Specify) 22 San Part Life The classes, of Commission of the Comments of Chip of Comments of Chip of Code, State 2p Code, Sta			life. D	O NOT use retired	during most of work d)	ang		
Sequentially list conditions   Thomas   Miller   Daisy   Pearl   Elliott	9		Tr	ainman			•	oad
19a. Informant's Name/Relationship (Type. Print)  James W. Miller / son  19b. Mailing Address (Street and Number or Rural Route Number. Chy or Town, State, Zip Code)  14003 Cedarwood Drive, SW, Cumberland, MD 21502  20b. Method of Deposition  14003 Cedarwood Drive, SW, Cumberland, MD 21502  20b. Method of Deposition (Number of Rural Route Number. Chy or Town, State)  20b. Method of Deposition (Street and Number of Rural Route Number)  21 Styraphreof Funeral Service Llocations and Cedar Control of Comments			M# 7 7 - 10					E114644
James W. Miller / son   14003 Cedarwood Drive, SW, Cumberland, MD 21502								
Cumberland   Cumberland   Cumberland   Cumberland   Crematory   2/4/2008   Cumberland   MD		· · · · · · · · · · · · · · · · · · ·						
Cumberland Crematory 2/4/2008   Cumberland Crematory 2/4/2008   Cumberland Combine	20a. Method of Disposition	20b. Pla	ace of Dispos	ition (Name of	i			
22. Signature of Funeral Serves Listoniae  4.04 Decatur Street, Cumberland, MD 21502  23. Part, Brioth the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, production of the cause of cachiline. List only one cause on each line.  23. Enter Undergring  23. Date of delivery  Month Day Year  24. Was an an autopsy performed personal under Undergring available appears  24. Was an an autopsy performed personal undergring available appears  24. Was an an autopsy performed personal undergring available appears  24. Was an an autopsy performed personal undergring available appears  24. Enter Undergring  25. Elize Death (Enter and Number or Rural Boute Number, City or Town, State)  26. Place of Death (Enter and Number or Rural Boute Number, City or Town, State)  27. Manager Death  28. Enter Undergring  28. Enter Undergring  28. En		noval from State				/2008	Cumberla	and, MD
23a. Part I. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arriest, immediate Cause (Final disease or conditions).  Sequentially list conditions are consequence of):  Due to (or as a consequence of):		A	22.	Name and Addres	ss of Facility Ada	ams Fami		
Immediate Cause (Final disease or condition resulting in death)   Due to (or as a consequence of):	Mun X (1)	dam	4	04 Decat	ur Street	c, Cumbe	rland, MI	21502
IFFEMALE:   23c. If yes, outcome pf pregnancy   23d. Date of delivery   23d.	23a. Part1. Inter the disease, or complica shock, or heart failure. List only one	itions that caused the death. cause on each line.	Do not ente	r the mode of dyin	g, such as cardiac	or respiratory arre	est,	Interval Between
Due to (or as a consequence of):    Due to (or as a consequence of):	disease or condition	CHRONIC	OB	STRUC	TIVE F	UI MONI	ARY DIS	
FEMALE:   23b. Was decedent pregnant in the past 12 months?	resulting in death)	Due to (or as a conseque	ence of):				/	
FEMALE:   23b. Was decedent pregnant in the past 12 months?	Sequentially list conditions,	Due to (or as a consequ	ence of):					
FEMALE:   23b. Was decedent pregnant in the past 12 months?	cause. Enter Underlying Cause (Disease or injury	But to for at a conseque	01,00 01,1					
23d. Date of delivery   23d. Date of death?   23d. Date of d	that initiated events C.	Due to (or as a conseque	ence of):					
23d. Date of delivery   23d. Date of death?   23d. Date of d	L <sub>d.</sub>							
23d. Date of delivery   23d. Date of death?   23d. Date of d	IE EEMALE:						1	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   CHINRONARY   ARTERY   D15 CR86    1   Ves 2   No 3   Probably 4   Onknown	23b. Was decedent pregnant 23c	1 ☐ Live birth 2 ☐ Fetal	death 3□l		,			,
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobacco use contribute to the cause of death?	1 ☐ Yes 2 ☐ No		ath 5□	Other (specify)			World	Day Teal
24a. Was an autopsy findings available prior to completion of cause of death?  25. Was case referred to medical examiner?  1   Yes 2   No  26. Place of Death (Check only one)  27. Mannaged Death		ibuting to death but not resul	ting in the und	derlying cause giv	en in Part I.	23e. Did tot	pacco use contribu	te to the cause of death?
24a. Was an autopsy findings available prior to completion of cause of death?  25. Was case referred to medical examiner?  1   Yes 2   No  26. Place of Death (Check only one)  27. Mannaged Death	CHORONARY ART	ERY DISE	4515			1 □ Ye	es 2 No 3	Probably 4 Onknown
25. Was case referred to medical examiner?    1						24a. Was a	n 24b. Wer	e autopsy findings available
25. Was case referred to medical examiner?  1						autops	y prior deat	r to completion of cause of th?
1   Yes 2   Mo  27. Manney of Death 1   Matural 2   ER/Outpatient 3   DDA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)  28a. Date of Injury 2   28b. Time of Injury 3   28c. Injury at Work? 1   Yes 2   No  3   Suicide 4   Homicide   28e. Place of injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, building, etc. (Specify)  29a. Certifier (Check only one)   1   Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)   29c. License number   29d. Date signed (Month, Day, Year)   29c. License number   29d. Date signed (Month, Day, Year)   36c. Registrar's Signature   29d. Date signed (Month, Day, Year)   29d. Dat	25. Was case referred to medical				26. Place of Deat			Yes 2⊠ No
27. Manner of Death 1		spital: 1 🎇 Inpatient 2 🗆 E	R/Outpatient	3 DDA Oth	er: 4 Nursing Ho	ome 5 Reside	ence 6 Other	Specify)
2   Accident 3   Suicide 4   Homicide   28e. Place of injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)   29a. Certifier (Check only one)   2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)   29d. Date signed (Month, Day, Year)   29d. National Highway, LaVale, MD 21502   31. Date filed (Month, Day, Year)   32   Registrar's Signature				28c. Injur Worl				
29a. Certifier (Check only one)  29b. Signature and title of certifier 29b. Signature and dadress of person who completed cause of death (Item 23a) (Type, Print)  Shiv C. Khanna, M.D., 1221 National Highway, LaVale, MD 21502  31. Date filed (Month, Day, Year)  32b. Erace of Imply - At norme, farm, street, factory, office 22b. Erace of Imply - At norme, farm, street, factory, office 22b. Erace and Number of Hural Houte Number, 22b. Location (Street and Number of Hural Houte Number, 22b. Location (Street and Number of Hural Houte Number, 22b. Location (Street and Number of Hural Houte Number, 22b. Location (Street and Number of Hural Houte Number, 22c. Location (Street and Number of Hural Houte	2 ☐ Accident investigation							
(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  D0054004  February 4, 2008  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Shiv C. Khanna, M.D., 1221 National Highway, LaVale, MD 21502  31. Date filed (Month, Day, Year)  38. Registrar's Signature		28e. Place of injury - At hon building, etc. (Specify)	ne, farm, stre	et, factory, office				r Rural Route Number,
(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  D0054004  February 4, 2008  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Shiv C. Khanna, M.D., 1221 National Highway, LaVale, MD 21502  31. Date filed (Month, Day, Year)  38. Registrar's Signature	29a, Certifier 1 X Certifying Physic	ian: To the best of my know	/ledge, death	occurred at the tir	ne, date and place	and due to the o	ause(s) and manne	er as stated
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shiv C. Khanna, M.D., 1221 National Highway, LaVale, MD 21502  31. Date filed (Month, Day, Year)  32. Registrar's Signature	(Check only 2 Medical Examine	er: On the basis of examination	on and/or inv	estigation, in my o	pinion, death occur	rred at the time, d	ate and place, and	due to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shiv C. Khanna, M.D., 1221 National Highway, LaVale, MD 21502  31. Date filed (Month, Day, Year) 32. Registrar's Signature	29b. Signature and title of certifier	7/1				2		
Shiv C. Khanna, M.D., 1221 National Highway, LaVale, MD 21502  31. Date filed (Month, Day, Year)  32. Registrar's Signature	1 m	Klam			0054004		F'ebrua:	ry 4, 2008
					hway, La	Vale, MD	21502	
	31. Date filed (Month, Day, Year) FEB 0 5 2008			Co)				

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year 735 PM June Eleanor Mallow ebruary 4, acust 1,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Lions Ctr. for Rehab and Ext. Care Cumberland Allegany | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Days | Hours | Min. | 06/23/1938 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F 69 Maryland Director 219-34-7167 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1X Yes 2 □ No Director MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21502 1522 East Oldtown Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify ð Specify: 3 ☐ Widowed 4 X Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cashier Retail 12 permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If item 27 Is marked other any injury or other traumatic event, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Senkbeil William Earl Northcraft Mildred Virginia ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19100 Fair Oaks Lane, NE., Flintstone, MD 21530 Robert J. Mallow / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Lutheran Cemi 2/8/2008 Cumberland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** META STATE 1 COLON CANCEY 6 unovain /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading 15 immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed physician and strans Due to (or as a consequence of): Box 68760. Physician/Medical as attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the 9☐Unknown 9 Unknown by signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown AKFITS MERCITA Completed itypencensia 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No certificate has page 2: autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After the Hospital or Attending 5 ☐ Pending investigation 1 Natural 2 ☐ Accident Injury death. 1 ☐ Yes 2 ☐ No Director: In 24 hours.

the Funeral Directory filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

nas

To the within

2 3

> State Registrar

(Check only one)

31. Date filed Mo

29b. Signature and title of sertifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Son

2. Registrar's Signature

)<u>on</u>a

Month, Day, Year)

FEB 0 5 2008

29c. License number

29d. Date signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. ZUUR Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Helen Anna Mankiewicz 2008 29 3:35 PM Jan. /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours 1 ☐ M 2 🔀 F 216-01-4681 91 Yrs. Director Maryland March 04,1916 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at MD Anne Arundel Severna Park Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 376 Magothy Road 21146 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 □ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working lile. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Head Custodian Baltimore City Schools of Health and Mental Hygin Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vincent Mroz Anna Balcer ပ traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Joseph Mankiewicz/Son 323 Community Road Severna Park, MD 21146 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hillcrest Memorial Date 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If ite
any injury or ot. Feb. 02, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cometery

22. Name and Address of Facility
Barranco & Sons,
Ritchie Annapolis, Maryland 2008 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MARDIN **Physician** disease or condition resulting in death) MUGDIATE /Medical Due to (or as a consequence of) Examiner JSCHEMIC) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician ar s the burial-to Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the a page 2 should be detached ☐ Yes 2 XNo 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform certificate 1 Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes P 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Ath 1 Natural 2 Accident 28a. Date of Injury 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred (Month, Day 5 Pending investigation death. Director: / 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) lor A 4 Homicide within 24 hours at To the Funeral D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

2004

31. Date filed (Month, Day, Year) **FEB 0 1 2008** 

EVINJ

30. Name and

32. Pegistrar's Signature

OKEFEND

address of person who completed cause of death (Item 23a) (Type, Print)

of Species

2003 MODICAL PARKWAY

Registrar

			1 - For State Registrar	State of M	Maryland /	Departme Certifica		ealth and l Death	Mental H	ygien  Reg. No	_ U U U	04879
	Physici		Decedent's Name (First, Middle, THERESA	,	MENDELE	WSKT			2. Date of D Month FEBRUAL	Da	y Year	3. Time of Death 5:15 P
	/Medi Examir		4a. Facility Name (If not institution,				y, Town, or I	Location of Death			c. County of Deat	
-			NATIONAL LUTHERA	AN HOME			ROCE	KVILLE				GOMERY
	Funeral Director		5. Social Security Number 081–12–0348	6. Sex 7 1 ☐ M 2 🖾 F	Age (In yrs. last i	Yrs. If Unc	er 1 Year s Days	If Under 24 Hrs. Hours Min.	(Month I	Day, Year	9. Birt. <i>Co</i>	hplace (State or Foreign untry) NEW YORK
5	A.		Usual Residence of Decedent							,		
	irylan ihow	_	10a. State 10b. County		10c. City, To	own or Location						10d. Inside City Limits 1 X Yes 2 ☐ No
	the Marylan 28s-f ahow	Director		ONTGOMERY				KVILLE		10.0		L,
	with the	Dire	10e. Street and Number	TDG DDTUG		101. 4	Zip Code			10g. C	itizen of What Co	
	ns 23	eral	9/UI VI	IRS DRIVE	nt Ever in U.S.	13. Was Dec	edent of His	20850 spanic Origin? (S	pecify Yes or f	10-	U.S.	rican Indian,
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heelth and Mental Hyglene. If item 27 is marked other than "natural", or items 23s or 28s-f ahow or other traumatic event, the Mulical Examination must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force	s? Z¥No	If Yes, s	ecify Cuban	Specify:	o Rican, etc.)		Black, White Specify: WI	a, etc. HITE
9	2 hou	ted	15. Decedent' (Specify only highest	s Education	16	Sa. Decedent's U	sual Occupa	tion uring most of wor	rking	16b. l	Kind of Business/	Industry
1215-0036	within 7 ene. than "n	Completed	Elementary/Secondary (0-12)	College (1-4c	or 5+)	life. DO NOT	use retired)		NII I Y		OUN III	ME
d 21	Hygie ther		17. Father's Name (First, Middle, L	ast)		- 11		18. Mother's Nar	ne (First, Midd	le, Maide	OWN HO	ME
Maryland	Mental Mental arked o	To Be	JOSE	PH GROMBLI	NIAK				MAF	YANN	PLITCHA	A
ary	2 should and Men is marke surmatic	1	19a. Informant's Name/Relationsh		12						or Town, State, 2	0000
111	1 and 2 Heelth em 27 i	11 3	MARYANN HAYUNGA/	DAUGHTER			Commence of the Commence of th	STREET	, KENSI	-	N, MARYI	
Baltimore,	Peges 1 nent of H int: if ite iry or otl		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp		te CEMET RESUL	of Disposition (*) tery, crematory of FERY OF RRECTION	r other place THE	02/0	7/2008	150005400	ocation - City or	
Balti	permit. Peg Depertment important: i any injury o		21. Signature of Funeral Service L	icensee		DANZ	and Address	s of Facility	G MEMOR	IAL	CHAPELS.	-
4.			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caus	ed the death. D							Approximate Interval Between
B	Physician	6 2	Immediate Cause (Final disease or condition	Adv	ansee	& Der	ven	tea				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequenc	ce of):	- 4	1 p (	0	0		
	- Administra	PL	Sequentially list conditions,	b. Due to (oc.	as a consequence	verta	avo	Jair	an			
	uted d ansit	E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Con	anar	n Sie	and I	desi	rasp			
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9 ×	ertifica ding pl		IF FEMALE:	220 H voc autoor	no of prognancy					ĺ	60.0	
Вох	that the death certifed by the attending detached for use e	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 ☐ Fetal dea at time of death						23d. Date of del Month	Day Year
0	the d	ysk	1 □ Yes 2 ☑ No 9 □ Unknown	9☐ Unknowr		323	(apoon))					
Records, P.	uires that the signed by th Id be detache	þ	Part II. Other significant condition	ns contributing to deat	n but not resulting	g in the underlyin	g cause give	n in Part I.	1	oltobacco ]Yes 2		the cause of death?
Ö	law requires as been sign 2 should be	Completed							24a. W		24b. Were as	utopsy findings available
Re	sicien: The law certificate has birector, page 2 s	Elo							pe	topsy rformed? : 2 1218	death?	completion of cause of
of Vital	ysicien; is certifica director, p	Bec	25. Was case referred to medical examiner?					26. Place of				
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n c	ling P. After t funera	lon:	27. Manner of Death  1 Natural 5 Pending	4	njury Da <i>y Ye</i> ar) 28t	o. Time of Injury M	28c. Injury Work	at ? ∕es 2 ∐No	28d. Describ	e how inj	ury occurred	
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place of	Injury - At home, etc. (Specify)	, farm, street, fac			28f. Location City or 1	(Street a	and Number or Ri	ural Route Number,
Ճ	ital or its afte rai Dir led in											
	24 hours Funeral etely filled	Medical		g Physician: To the be Examiner: On the basis and manner	of examination							
	To the within 2 To the comple	Me	29b. Signature and title of certifier				29c. License	number		29d. D	ate signed (Mont	th, Day, Year)
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(			30. Name and address of person									
			DR. XIAO-CHUN				VORLD	BLVD, SI	LLVER S	PRIN	G, MARYL	AND 20906
	St: Regist	ate	31. Date filed (Month, Day, Year)	nns Reg	strar's Signature	hout 8						

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death inysiciañ Month Dav Year Theodore Hart McNelly 6:00 February 01 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1⊠M 2□F Months Hours Min 720-16-1994 Director 88 December 27,1919 Wisconsin Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2kī No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14800 Cobblestone Drive Funeral 20905 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No ģ Specify Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Professor University of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stephen Sumner McNelly ဥ Caroline Taylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myra M. McNelly - Spouse 14800 Cobblestone Drive, Silver Spring, Maryland 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Forest Hill Cemetery 02/08/2008 Madison, Wisconsin 21. Signature of Funeral Service Licer see 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. Nana 10 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca (Final disease or condition resulting in death) **Physician** Pricuratia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Fun emia Examiner Due to (or as a consequence of): the death certificate be executed Sepsis and burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No autopsy performed' 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes 2**⊠** No 2 ☐ ER/Outpatient 3 ☐ DOA 1 XI Inpatient this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of After Certification: 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 X Natural 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No sampletely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D65 305 February 2, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nabila Farhat Khan, M.D., 1500 Forest Glen Road, Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) Registrar's Signature State FEB 04 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 29 2008 430 M ahvary /Medical **Examiner** 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Bay 523 ocionantown 03217r If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday Date of Birth (Month, Day, Ye Aug. 20, 9. Birthplace (State or Foreign **Funeral** Days Year) Hours 1 ₩ M 2 □ F 219-46-8118 61 Yrs. 1946 Washington, Director Aug. Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2√☐ No Directo Maryland Montgomery Germantown 10e. Street and Number 10g, Citizen of What Country? 18523 Bay Leaf Way Funeral 20874 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🗶 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White þ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Electrician Electrical Engineering Pages 1 and 2 should be filed an ment of Health and Mental Hygis ant: If item 27 is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Marzo Helen Dick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Turnersville, NJ 08012
Date 20c. Location - City or Town, State Mary Lou Tweed/Sister Whitman Drive, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite 4 Feb. ¥¥Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery injury 4 □ Donation 5 □ Other (Specify) 2008 Silver Spring, Maryland 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licenses 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause on each lin-Approximate Interval Betwe Onset and De Physician Immediate Cause (Final disease or condition resulting in death) 6 1500 50 79/UE /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tra that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9☐Unknown 9 HInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been si should l 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an ate has bage 2 s autopsy performed? Yes 2 No certificate 1□ Yes the Hospital or Attending Physician: director, 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hours the Funeral Directory its filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 ho To the Fund completely f Medical (Check only anature and title of ertifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. mo DME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar moomE

32 Registrar's Signature

SHRE

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31. Date filed (Month, Day, Year)

FEB

**Physician** /Medical Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

"natural", or items 23a or 28a-f show dical Examiner must be notifled at

The law requires that the death certificate be executed attending physician and for use as the burial-trar ed by the a been signe should be o To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: Atter this certifica director, filled in by the funeral

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Certification:

Medical

Division or Vital Records, P.O. Box 68760,

26. Place of Death (Check only one)

28d. Describe how injury occurred

25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 🔀 No 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 5 ☐ Pending investigation 1 Natural

Other: Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

2 Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

6 ☐ Could not be

29c. License numbe D09834

29d. Date signed (Month, Day, Year) Reb.4,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barry Rosenbaum M.D.

3720 Farragut Avenue Kensington, Md 20895

State Registrar

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DHMH 17 Rev 1/2001

			For State Registrar	State of	Marylar		artment of F <i>rtificate of</i>			21	008	01.88	1
		ę.	Registrar  1. Decedent's Name (First, Middle	, Last)		Cer	illicate of	Deatti	2. Date of De	Reg. No \	100	3. Time of Death	ر ا ا
	Physicia		MIKE	AL WAYNE M	4TLLER				JAN 2	7 2008	Year	4:07 A	М
	/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town, o	r Location of Deat			ity of Death		
		2	NATIONAL NAVAL			-		HESDA			40NTGC		
	Funeral Director		544-21-2317	6. Sex 7 1 X M 2 ☐ F	7. Age (In yrs. 22	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Pa Aug • 2	, Year 985	9. Birth Cou Lake	place (State or Fore intry) view, OR	ign
	and ow t		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation					10d. Inside City Lim	its
	Maryl fied a	to	OR Linr	1	A	lbany						1 <b>⊠</b> Yes 2 □	No
	h the or 28a e notifi	Director	10e. Street and Number				10f. Zip Code			10g. Citizen o	f What Cou	ntry?	_
	th wit	a D	2776 NW 12th Av	renue			97	321		U	SA		
٥	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Maritał Status 1	12. Was Deced Armed Ford 1 X Yes 2	dent Ever in U ces? 2003- tes: 2008	.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛣 No	lispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No to Rican, etc.)		ace - Ameri ack, White,	, etc.	
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2	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, L	ast)		, 1111	andL)	18. Mother's Nar	me (First, Middle	, Maiden Surna	ame)		
	ould b Ment arked artic e	To	Steven Wayne Mi	.ller					onna Bla				
מפו	12 sh h and r Is m raum		19a. Informant's Name/Relationsh 'Megan Rae Miller				ng Address <i>(Street</i> NW 12th				n, State, Zij	p Code)	
ָ ע	1 and Health em 27		20a. Method of Disposition	./ WIFE	20b. F	L Place of Dispo	sition (Name of		Date T	20c. Location	- City or T	own State	
5	Pages ent of nt: If II		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sc	3 □Removal from S	tate Wili	cemetery, crei Lamette 1	natory or other pla Nat. Cemete	ry Feb.	1, 2008	Portla	•		
Dalling	permit. I Departm Importar any injui		21. Sign tyre of Funer Service	1		Ã	2. Name and Addre	ess of Facility neral Hon	ne 4510			A51203V4	1
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	/Medical		disease or condition resulting in death)		AST INJ oras a conseq		OF THE H	EAD	-				_
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O. DO.	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2☐Feta int at time of c	aldeath 3□	Ectopic pregnanc Other (specify)	у	<del></del>		Date of deliv Month	rery Day Year	
	w requires that the de been signed by the should be detached		Part II. Other significant condition	ns contributing to dea	ath but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use co	ntribute to	the cause of death?	
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ב	urs aff						LEFIELD		BA	GHDAD			_
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or property.	edical	29a. Certifier 1 Certifying (Check only one)  2 XMedical E	g Physician: To the b Examiner: On the bas and manne	sis of examina	owledge, deatl ation and/or in	n occurred at the til vestigation, in my o	me, date and place opinion, death occi	e, and due to the urred at the time,	cause(s) and r date and place	nanner as s e, and due t	stated. to the cause(s)	
	To the vithin To the comple	Me	29b. Signature and title of certifier	and manne	otatoa.		29c. Licens	e number		29d. Date sign	ned (Month,	, Day, Year)	_
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2	2		30. Name and address of person v			usar (Type,	Print) ARMED	FORCES :	INSTITUT 20850				_
	Sta		FITZABETH A. RO 31. Date filed (Month, Day, Year)	32. Reg	gistrar's Signa	ture		THE LIE	20000				
	Registra	ar	FEB 0 4 2008	Klasse	K	bethe							

			For State Registrar	State of Marylar		artment of H <i>tificate of L</i>		_	6.	008	04	884
			Decedent's Name (First, Middle, La	st)				2. Date of De	Reg. No.		3. Time o	of Death
L	Physici		ANNIE LAURA	Mc CRAW				January	Day 25.	2008	10.1	LOP M
Prope	/Medi Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	Januar	_	ounty of Death	10.1	LOI
/ 			2405 MUNCY CIR			LANDOVE	R		PRI	INCE GEO	ORGES	
	Funeral		Social Security Number 6. 8	Sex 7. Age (In yrs.	. last birthday)	If Under 1 Year Months Days		8. Date of Bir (Month, Da	th	9. Birthp	lace (State	or Foreign
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	pu »		Usual Residence of Decedent  10a. State 10b. County	100 0	ty, Town or Lo	nation						
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	with t		10e. Street and Number	or 5		10f. Zip Code	-		_	n of What Cour		
	s 23g	Funeral	2405 MUNCY CIR		10 100	2078			UNITE			
	item item ner.n	ů,	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	-   14	<ul> <li>Race - Americ Black, White,</li> </ul>		
36	rs aft r, or kami	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1	☐Yes 2☐No	Specify:		S	pecify: BI	LACK	
215-0036	tura sal E	ed	15. Decedent's E	ducation	16a. Deced	lent's Usual Occupa	ation		16b. Kind	of Business/Inc		
15	nin 72 n "na Medik	plet	(Specify only highest grant Elementary/Secondary (0-12)	ade completed)  College (1-4or 5+)	(Give	kind of work done d OO NOT use retired,	luring most of work )	ting				
212	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	7+h	-0-	HOTEI	MAID			HOSPI	TALITY		
פ	be filed within 72 hours after death with the Marylan tial Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	BeC	17. Father's Name (First, Middle, Last				18. Mother's Nam	e (First, Middle,	Maiden Su	urname)		
Maryland 21	should be nd Mental marked c	To B	HENRY JOHNSON				ANNIE :	raynhan	1			
a			19a. Informant's Name/Relationship (	Type. Print)	19b. Mailin	g Address (Street a						
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e e	es 1 and of Healt f Item 2: r other		20a. Method of Disposition	20b.	Place of Dispos	sition (Name of natory or other place	e)	Date	20c. Loca	tion - City or To	wn, State	
Ĕ			1 ☑ Burlal 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia	Themoval Irom State	.coln Me		1	02, 08	Suit1	Land, Ma	arvlar	nd
Baltimore,	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Live			. Name and Addres						
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58/50,	ificate be executed g physician and as the burial-transit	edical		▲d								
XO	± 00 m	/Me	IF FEMALE:	23c. If yes, outcome pf pregn	ancy							
9	death certifi e attending d for use as	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a	al death 3	Ectopic pregnancy Other (specify)			230	<li>Date of delive Month</li>	ny Day	Year
j	the d	hysician/M	1 □ Yes 2 🛣 No 9 □ Unknown	9□Unknown	jeaiii 5	Other (specify)						
Γ	w requires that the d been signed by the should be detached	_	Part II. Other significant conditions	contributing to death but not res	sulting in the un	derlying cause give	n in Part I.	23e. Did to	bacco use	contribute to th	e cause of	death?
S	uires sign Id be	d by	CHRONIC OBSTRU	CTIVE LUNG DIS	EASE			1 🗆 \	/es 2 <b>⊠</b> 1	No 3□Prob	ably 4 🗌	Unknown
	law req as beer 2 shou	Completed						24a. Was	an (	24b. Were autor	nov findings	ovoilable
Ď Ľ	The la te has page 2	Ę						autop		prior to cor death?	npletion of	cause of
		ပို	25. Was case referred to medical				26. Place of Deat		2 X No	1 ☐ Yes	2 <b>X</b> No	
>	Physiclan: r this certificaral director,	0 8	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 DOA Othe				70thor (Cas-:	d	
0	g Ph erati	$\vdash$	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury Work		28d. Describe h			′/	
NISION	I or Attending F after death. Director: After I in by the funera	cation:	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		? ′es 2 □ No					
<u> </u>	l or Attend after death Director: /	ertifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At h building, etc. (Specia	ome, farm, stre	et, factory, office		28f. Location (S	Street and N	 Number or Rura	l Route Nur	nber,
5	= <u>a</u> # <u>o</u>	P.	_	Landing, Old. (Open	31			Unty Of TON	ii, Glate)			

of 5

State Registrar 29a. Certifier

29b. Signature and title of certifier

Douglas VanZoren, MD. 1011 N. Capitol Street N.E. Washington, D.C.

31. Date filed (Month, Day, Year)
FEB 0 7 2008

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

LX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DC 15632

29d. Date signed (Month, Day, Year)

February 01, 2008

Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryland		artment of F rtificate of			giene leg. No. 200	8 04886
et n	Physici /Medio	cal	Decedent's Name (First, Middle, Las     JOANNE MASS	EY				2. Date of Dea Month FEBRUA	PY 11 2	008 12:23a <sup>M</sup>
	Examir Funeral	er	4a. Facility Name (If not institution, give  Chester River  5. Social Security Number 6. Se	Hospital  7. Age (In yrs. Ia	ast birthday)	If Under 1 Year	tertow If Under 24	/n Hrs. 8. Date of Birth	4c. County of D	
	Director		212-40-8908 10 10 10 10 10 10 10 10 10 10 10 10 10	M 2 <b>¾</b> 67	Yrs.	Months Days	Hours N	Apr 4	1940 De	elaware
	r 28a-f shov notified at	Director	,			ville 10f. Zip Code		1	0g. Citizen of What	10d. Inside City Limits 1 ☐ Yes 2 🔀 No  Country?
15-0036	be filed within 72 hours after death with the Maryland ital Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Funeral D	1316 Millingto  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Ed. (Specify only highest grade)	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: ucation te completed)	16a. Deced	21666  Nas Decedent of H  Yes, specify Cubic  Yes 2X No  dent's Usual Occup kind of work done	ispanic Origin' an, Mexican, P Specify: ation	? (Specify Yes or No- uerto Rican, etc.)	U.S.A. 14. Race - A Black, W	merican Indian, Ihite, etc. White
71 Z DL	e filed within all Hygiene. other than "	Be Com	Elementary/Secondary (0-12)  1 2  17. Father's Name (First, Middle, Last)	College (1-4or 5+)		er - Op	erato	1	Restau Maiden Surname)	rant
Maryland	2 should be and Mental Is marked o aumatic eve	To B	Lawrence Masse  19a. Informant's Name/Relationship (7)		19b. Mailin	ng Address (Street		ita Madge		e, Zip Code)
Dallimore, IV	permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 Is marke any Injury or other traumatic once.		Bryan Jackson  20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Specify,  21. Sign 5  Fu eral Struce Donate Shock, or heapt failure. List only of	Ga M005  Ilications that caused the death,	lena 22 10 1	Cemeter Name and Addre alena F 18 West	y 2 ss of Facility unera Cross	/16/08 l Home of s St. Gal	Galena, Stephe Lena, MD	n I. Sahaoah
oo,	Physician but American but American but American and a the prival-transit at the prival-transit and a the prival-transit and a the prival-transit and a the prival-transit and a the prival transit	dical Examiner	Immediate Caus Final disease or continuon resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence.  Due to (or as a consequence.  Due to (or as a consequence.	ence of): ence ofj.	VCINOMA.	n of	Unknown	Primar	Onset and Death  One Augure
.O. DOX 0	The law requires that the death certificate ite has been signed by the attending physoage 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregnan 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
Cords, r	equires that en signed b ould be deta	þ	Part II. Other significant conditions co	ntributing to death but not resul	ting in the ur	derlying cause give	en in Part I.			e to the cause of death? Probably 4 ∏Unknown
ם שבי	i: The law re loate has ber r, page 2 sho	Completed						24a. Was al autops perforr 1∐ Yes 2	y prior ned? death	autopsy findings available to completion of cause of ? es 2 \( \text{No} \)
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Certification: To Be	25. Was case referred to medical examiner?  1		R/Outpatient 28b. Time of Injury ne, farm, stre	28c. Injun Worl	er: 4 ☐ Nursin	28f. Location (St.	ence 6 Other (Sow injury occurred	pecify)  Rural Route Number,
2	the Hospital or hin 24 hours afte the Funeral Dir npletely filled in		29a. Certifier 1 Certifying Phy	sician: To the best of my know iner: On the basis of examination	ledge, death	occurred at the tin	ne, date and pl	ace, and due to the ca	auso(s) and manner	as stated.
	To the F within 24 To the F complete	Medical	29b. Signature and title of certifier	and mahner stated.		29c. License			9d. Date signed (Mo	
	F S		30. Name and address of person who con Paul Donaher, 131. Date filed (Month, Day, Year)	M.D. 119 C.	Nort	h Main	St. G	alena, MI	D. 21635	
	Sta Registra		FFR 1 6 200	32 Registrar's Signatu	100	A Carlo				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗸 U U 🖔 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 11, 2008 Charles Michael McAuliffe February 11:10 A.M. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Solomons Nursing Center Solomons Calvert If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ▼M 2 □ F Director 91 008-05-1701 11-29-1916 Vermont Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at St. Mary's 1 ☐ Yes 2 No Director MD Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21895 Pegg Road 20653 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 3 Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles R. McAuliffe Mary T. Kelly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) , 1 and 2 st of Health ar fitem 27 l James G. McAuliffe (Son) 23024 Town Creek Drive, Lexington Park, Maryland permit. Pages 1 & Department of He Important: If item any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 02/12/08 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** METASTATIC CANCER disease or condition resulting in death) Wecs /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division or Vital Records. P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 - NO 2 - NO 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 Inpatient 2 ER/Outpatient 3 DDA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed, (Month, Day, Year) 734198 2/12/68 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Federle, MD 24035 Three Notch Road, Hollywood, Maryland 20636

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) FEB 1 6 2008

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2008 Bertha Virginia Noldy February 6:50 a<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital <u>Prince Frederick</u> Calvert 8. Date of Birth (Month, Day, Feb. 5, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🛛 F Virginia 86 578-24-1413 Director Usual Residence of Decedent t be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ▼No Director MD Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with 1530 Lincoln Lane 20678 items 23a U.S.A. Examiner must by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 er than "natural", or the Medical Exami 1 ☐ Yes 2 ☑ No Specify: Specify: 3 X Widowed 4 □ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government 12 should be filed w h and Mental Hygiel 7 **is marked other t** secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Pearl Minnick Roger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any Injury or other traum Julia E. Bass, daughter 1530 Lincoln Lane, Prince Frederick, MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🎇 Burial 2 □ Cremation 3 □ Removal from State Lakemont Mem. Gardens 02-06-2008 Davidsonville, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** onjestive heart disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner cardiony Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed Due to (or as a consequence of): sician and burial-tran arperu physician Adenocarcinoma Physician/Medical aftending place as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 Other (specify) the 9□Unknown 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ disease 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed atrial 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No has page 2 autopsy certificate Hypertension performed' 1∐ Yes 2 **W**No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital 1 🔲 Yes Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Many r of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

Division or Vital Records, P.O. Box 68760.

To the within 2

State Registrar

31. Date filed (Month, Day, FEB

29a. Certifier (Check only one)

29b. Signature and title of certifier

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JABER 100 HOSPITAL RO. Year) 32. Registra Signature

2008

and manner stated.

PRINCE FREDERICK, MO

29d. Date signed (Month, Day, Year)

2008

02/03

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 60390

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 17 per fh e8/6 2-25-08 vt. State of Maryland / Department of Health and Mental Hygiene State Registra/Amend#19a.PenFHPGC2-12-08cm Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Georgia C. Nugent 8:05 PM 2/3/2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Villa Rosa Nursing Home Prince George's <u>Mitchellville</u> If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🖺 F Director 213-40-9076 66 2/2/1942 Washington, D.C Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Director MD Prince George's Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 Crescent Rd. Apt. A 20770 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. ≥ Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life DO NOT use retired)
Certified
Registered Nurse Assistant Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Southern Maryland Elementary/Secondary (0-12) College (1-4or 5+) Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles G. Doonis <del>Charles Doonia</del> Annarosa Margaret Christiani Francis P. Nugent, Jr. -Husband Frank P. Nugent, Iusband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Crescent Rd., Apt A, Greenbelt, MD 20770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department o Important: if any injury or = 5 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 2/5/2008 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Lung Carcinoma Months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) law requires that the death certificate be executed attending physician and for use as the burial-trai resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death signed by the a 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s perform certificate 2X No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2X No 2 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one)

31. Date filed (Month, Day, Year) State FEB 0 6 2008 Registrar

30. Name and address of person

29b. Signatu

nd tipe of certifier



no completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

D32261

29d. Date signed (Month, Day, Year)

February 4, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1- For Amend Item #5 State of Mary State Registrar WCHD/SH 2/12/08 per FH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Gladys Virginia ORNDORFF 4:46 P.M FEBRUAR 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Hagerstown Washington 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 2 1 6 – 38 – 0359 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Months Days 87 Director Dec.20,1920 Maryland Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 21 No Director Maryland Washington Williamsport 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or ? r must be r 16505 Virginia Avenue 21795 USA I and 2 should be filed within 72 hours after death Funeral ?7 Is marked other than "natural", or Items traumatic event, the Medical Examiner m 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) homemaker her own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental P Jobe Hill Bertha Shaw 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 I Joy Ebersole - daughter O. Box 79, Maugansville, Maryland 21767 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 tment of F Department of Important: If it any injury or conce. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 2/9/08 Hagerstown, Maryland 21. Signatur Truneral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician RECURRENT disease or condition resulting in death) MONTHS /Medical Due to (or as a consequence of Examiner ONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed GURGITATION resulting in death) Last Due to (or as a consequence of) Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 2. No Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PHEUMOTHOR 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s FIRRULATION 22 No 1□ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death Check onl one Hospital: 2 No Other: 4 Nursing Home 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide The critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE DRI 1/110 9 31. Date filed (Month, Day, State Registrar 7 2008

DHMH 17 Rev 1/2001

FEB 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Dorothy M. Oker January 30, 2008 11:00 РМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 19, 1 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🗷 F 289-10-1925 Director 93 1914 Ohio Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Maryland Montgomery Gaithersburg 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20877 420 Belle Grove Road United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🛛 No Specify: White 3 127 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper/Secretary Dairy 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Claude Johnson Francis Nauman ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 420 Belle Grove Road, Gaithersburg, MD 20877 19a. Informant's Name/Relationship (Type, Print) Diana J. Johnson (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan 20a. Method of Disposition Date 20c. Location - City or Town, State February 2 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Exematory 2008 <u>Alexandria, Virginia</u> 22. Name and Address of Facility 21. Signature of Funeral Service Licenses DeVol Funeral Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part I Enter In Assa e, or complications that cause it have eath. Do in tenter the mode of dying, such as cardiac or respiratory arrest, shock, or hyar tailure. List nly one cause on each line.

Immediate cause final disease or complication.

Assiration Pneumonia Approximate Interval Between Onset and Death Physician disease or contribution in death) Aspiration Pneumonia /Medical Due to (or as a consequence of) Examiner Atherosclerotic Vascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed and burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death ☐Yes 2 x No 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Atrial Fibrillation, Sick Sinus Syndrome 1 Tes 2 No 3 Probably 4 tdUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2<del>√</del> № 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ပ 2 X ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760. after death

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Amy Schiffman, M.D.,

FEB 05

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

9901 Medical Center Drive, Rockville, Maryland 20850

29d. Date signed (Month, Day, Year) February 01, 2008

			1 _ State	State of Ma	aryland.					lental Hy	giene	000	04892
	_	o	Registrar  1. Decedent's Name (First, Middle, Last)			Cer	tificate c	or Deatr	7	2. Date of De	Reg. No.	บบช	3. Time of Death
	Physic /Medi		HENRY G.	PAR	RKER					Februar	Day	2008	8:15 P M
	Exami		4a. Facility Name (If not institution, give st		4.		4b. City, Tow				4c. Co	unty of Death	
	Funeral		Winter Growth's H 5. Social Security Number 6. Sex		iter : (In yrs. last	t birthdav)	Col ur		er 24 Hrs.	8. Date of Birt	How		place (State or Foreign
	Director			M 2□F	94	Yrs.	Months Da	ys Hours	Min.	(Month, Da Aug. 7	y, Year)	Cou	ntry)  Iowa
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Lo	cation						10d. Inside City Limits
	Maryl -f sho fied at	tor	Md. Montgom	ery	-		sville						1 ☐ Yes 2 Mo
	th the or 28a e noti	Jirec	10e. Street and Number				10f. Zip Cod	е			10g. Citizen	of What Cou	ntry?
	leath with the Marylar ns 23a or 28a-f show must be notified at	ral	2904 Greencastle						866			ited S	
920	in 72 hours after death with the Maryland ""natural", or items 23a or 28a-f show ledical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	2. Was Decedent E Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:			Vas Decedento fYes, specify C ☐ Yes 2 1			ecify Yes or No- Rican, etc.)		Race - Americ Black, White, pecify: W	
2-0	72 ho 'natur dical l	eted	15. Decedent's Educa (Specify only highest grade	ation co <i>mpleted</i> )	1	I6a. Deced	lent's Usual Oc	cupation	est of worki	na	16b. Kind	of Business/In	ndustry
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d 2	illed Hygid other ent, tl	Be Co	17. Father's Name (First, Middle, Last)	6		CITE	mical F			(First, Middle,		notogra mame)	ipiire
ylar	Menta Menta arked atic ev	To B	Henry G. Parke	er				Pe	earl	Garde	ner		
, Maryland	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical Once.		19a. Informant's Name/Relationship (Type Craig W. Parker /	,		2904	Greeno	astle		Noute Number Burto			
Baltimore,	Pages 1 ient of Hi nt: If iten ry or oth		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	ceme	etery, cren	sition (Name of natory or other p tan Cre	olace)	2/5	)ate /08		ion - City or To kandria	
Balti	permit. Departrr Importa any inju		21. Signature of Funeral Service Licensee	Ban	her	22	Name and Ad Muriel	dress of Faci H. Bar	ber I	Funeral Laytons	Home		20882
	,		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	ations that caused to	the death. De.			_					Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Atria			tion						Onset and Death
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68760,	ficate be executed physician and s the burial-transit	edical E	d	Due to (or as a	consequen	ce or):							
			IF FEMALE:						-				
P.O. Box	the death certific the attending p ched for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	c. If yes, outcome p 1 □Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 Fetal de	ath 3 🗌	Ectopic pregna Other (specify,				23d.	Date of delive Month	ery Day Year
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al Records,	The ate has bage	Completed								24a. Was a autop perfor 1□ Yes	med?	prior to co death?	opsy findings available mpletion of cause of 2□ No
or Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	spital:				N		(Check only or			Living
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sion	Attending Prdeath.  ector: After by the funer	atio	1 Natural 5 ☐ Pending investigation	(Month, Day	Year)	Injury		/ork? ☐ Yes 2 ☐	]No				
Division	tal or Attress after de al Directre ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injur building, etc.	ry - At home, (Specify)	, farm, stre	et, factory, offic	се	2	8f. Location (S City or Tow	treet and No n, State)	umber or Rura	al Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) 1	cian: To the best of er: On the basis of e and manner state	examination	dge, death and/or inv	occurred at the estigation, in m	time, date a y opinion, de	ath occurr	and due to the dead at the time, d	ause(s) and date and pla	d manner as s ice, and due to	tated. o the cause(s)
	vith To t	Σ	29b. Signature and title of contifier					nse number	-,		29d. Date si	gned (Month,	Day, Year)
,	1	-	30. Name and address of person who com	ploted course of do	ath (Hom 02	2) (7:00- 5		005	184	1		21	4/08.
	1		Brian L. Glenn, M.  31. Date filed (Month, Day, Year)	D. 125	20 Pro	sper	ity Dri	ve, Si	lver	Spring	, Md.	20904	
	Sta Registr	.~	FEB 0 6 200	32. Tegistrar	J. Signature	Sp	and in						

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 06893 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death y Year 7008 Month Day Physician MAMOUS HTIBUC 2:10 9 M February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** BULLIE Anne Arunde Baltimore Washington Medical Center Elen 8. Date of Birth (Month, Day, Ye Oct. 2, 1 5. Social Security Number 6. Séx 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🛛 F Days Hours California 65 530-28-7792 Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits Funeral Director 1 ☐ Yes 2 No WVJefferson Harpers Ferry 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be r 152 Old Shenandoah Trail 25425 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2√2 No Specify. Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Bookkeeping 4 or other traumatic event, land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be It of Health and Mental 1 and 2 should be Guy Cantwell 2 Nelsyne Knebel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald B. Pullman - Husband P. O. Box 258 - Harpers Ferry, WV 25425 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Himportant: If ite any injury or ot Pages 1 XBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u> Pleasant View Mem. Gar. 2/7/08</u> | Martonsburg, WV 22. Name and Address of Facility Eackles-Spencer & Norton Funeral 21. Signature of Funeral Service Licensee Rober M970 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Home - Harpers Ferry, WV 25425 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPTIC SHOCK 2 DAYS /Medical Due to (or as a consequence of): Examiner URIVARY TRACT INFECTION Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 2 MAG F Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Hlnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2243210 VARHONIUS SUITSURTERO DICENSE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 
No 24a. Was an 2 No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ō within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) an confuer orangon HD 00062714 BOOF I PARMABJ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CUILLERMO JOSE CIANCRECO 301 HOSPITAL DRIVE, GLEW BURNIE, MD 20161 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) State Registrar 0 6 2008

DHMH 17 Rev 1/2001

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oll man,

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

"natural", or Items 23a or 28a-f show edical Examiner must be notified at

the Medical

traumatic event,

permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked any liginy or other traumatic evone.

Director

Funeral

Completed by

Be

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Examine

Physician/Medical

Be Completed by

Certification: To

Medical

State

Registrar

2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show

Baltimore, Maryland 21215-0036

and burial-trai attending physician for use as the buria ed by the a cate has been signed by page 2 should be detack

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760

within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

•	d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	23d. Date of delivery  Month Day Year
	contributing to death but not resulting in the underlying cause given in Part I. THROM BOSIS	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknow
		24a. Was an autopsy performed? 1 ☐ Yes 2X No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2X No 2 X No
25. Was case referred to medical examiner?	26. Place of Death (C	Check only one)
1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d	I. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 175 Certifying Pl (Check only one) 2 Medical Exa	nysician: To the best of my knowledge, death occurred at the time, date and place, and miner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier	byle mp 29c. License number D 004158	7 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

122 Speer Rd. Chestertown, MD. 21620

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Helen A. Noble, M.D.

1 2008

31. Date filed (Month, Day, Year)

FEB

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month Vaar Mary Paniczko February /Medical 4. 2008 2:10a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 15100 Glade Drive, #3A Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🗺 F Director 168-12-6672 88 Jan. 19, 1920 Pennsylvania Usual Residence of Decedent 10a. State 10c, City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified Director 1 ☐ Yes 2 V No Maryland Montgomery Silver Spring the 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ö 23a 15100 Glade Drive, #3A 20906 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite Black, White, etc. 1x Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ò Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+Civil Motions Commissioner DC Superior Court 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Adam Alexander Paniczko Adela Veronica Mrozowska other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen T. Paniczko/Sister 15100 Glade Drive, #3A, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Feb. Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State Mount Olivet Cemetery 2008 4 ☐ Donation 5 ☐ Other (Specify) Washington, DC 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licenses 500 University Blvd, W., Silver Spring, MD 20901 guy 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each one. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Infarction 14 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Intestinal Obstruction 21 days a consequen Examiner physician and s the burfal-transit be executed Due to (or as a consequence of): Box 68760 Physician/Medical as for use a IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. 1 Ves 2 No the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Hypertension 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy performed? Yes 2. XNo page certificate or Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2[**X**No Other: 4 Nursing Home 5 🗷 Residence 6 Other (Specify) P this 27. Manner of Death 28a. Date of Injury 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division or Attending 5 ☐ Pending investigation (Month, Day Year) 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) þ 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1080 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar 5 FEB 0

DHMH 17 Rev 1/2001

# FLO 化断化逆 PROCTOR Baltimore, Maryland 21215-0036

1000	
.O. Box 68760,	
Records, P	
or Vital	
Division	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U U 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY 2, 2008 **Physician** Proctor Florence E. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CIVISTA MEDICAL CENTER LA PUATA CHARLES If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1 ☐ M 2 😾 F MARYLAND Yrs. Director 578-40-2704 78 JULY 20 1929 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 No Director WASHINGTON, DC DC with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20019 5561 CENTRAL AVENUE S.E. Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23 ury or other traumatic event, the Me. Ical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: BLACK ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT 12th MAIL HANDLER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HORACE CECILIA M. PROCTOR GARDNER 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health at Important: If item 27 Is any Injury or other trau once. 7109 KENT TOWN DRIVE LANDOVER, MARYLAND 20785 TERRY JOHNSON/GRANDDAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MT. OLIVET CEMETERY 2/8/2008 WASHINGTON, DC 4 □ Donation 5 □ Other (Specify) Muneral Service Licensee J. B. JENKINS FORERAL HOME 21. Signature 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardio- Pulmonary **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atheroscierono Cardiovascular Dispace pertensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine signed by the attending physician and defached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed? 1□ Yes 2☑No Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ►R/Outpatient 3 ☐ DOA 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation Injury To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Marita Brune HO 00050332 Marta Broom no Emergency Physician 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 701 East Charles St. P.O. Box 1040 La Plata MD 20646 Broom Mante 31. Date filed (Month, Day, Year)
FEB 0 7 2000 32. Registrar's Signature Registrar

			For State Registrar	State of M	arylan		artment of F <i>rtificate of</i>			giene Reg. No 2	AΩ	01.897
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21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Ma 3 □ Widowed 4 ᅑૣDivorce	If Yes, Give	?	S. 13.	Was Decedent of H If Yes, specify Cub. 1 ☐ Yes 2 X No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		/·	
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Baltimore,	permit. Pages 1 a Department of Hee Important: If item any Injury or othe		21. Signature of Funeral Service	Licensee		2	2. Name and Addre	ss of Facility <b>J</b> O	rdan Fur			20019
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	Sta	te	Darryl Hill 31. Date filed (Month, Day, Year									
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	/Medio Examin		4a. Facility Name (If not institution, give Southern Maryland F		nber)			, Town, or	Location of	f Death		4c. Count	y of Death	
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12-0036	d within 72 hours after death with the Maryland glene. Ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	3007 Brinkley Road  11. Marital Status  1  Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Edi (Specify only highest grace)	Armed For 1 Test of Yes, Giv Year or Da	2∰No e	16a. Dece	1 ☐ Yes	XX No	Specify:		cify Yes or No- Rican, etc.)	14. Ra Bla Speci	ce - Ameri ack, White fy:	Black
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e, Mai	permit. Pages 1 and 2 should b Department of Health and Ments Important: If Item 27 Is marked any Injury or other traumatic er		19a. Informant's Name/Relationship (T) Patricia Dyson / Daug 20a. Method of Disposition		20b. F		Jaffre	ey Road	d Ft. V	Washii	ngton, Ma Pate		20744	
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2	shou ind M is mar umat		19a. Informant's N					19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	al Route Num	ber, City	or Town, S	tate, Z	p Code)	
	and 2 alth a 27 is		Daryl Er	ic Pils	on / Son								shingt					
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	Pag ment ant: 1 ury o			5 Other (Sp			Mary	yland						4			Marylar	1d 
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 burs after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical			d													
<	leath certific attending p	/Me	IF FEMALE:		23c. If yes, o	outcome	of pregnar	nev							23d. Date	of deli	verv	
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2	ng Pi		27. Manner of Dea	ath 5 □ Pendin	/8.6	te of Inju o <i>nth</i> , <i>D</i> ay	ry y Year)	28b. Time o injury		28c. Injur Wor	k?		28d. Describ	e how ir	jury occurre	ed		
2	tendi eath. tor: A the fu	catio	2 ☐ Accident 3 ☐ Suicide	investig 6 ☐ Could r	ation		A11-		M		Yes 2□	No	201 1	/04	and Musebook	- 0 - D	ral Route Nun	nhor.
2	or At fitter d Direct in by	Certification:	4 ☐ Homicide		inod   Zoe, Pld	ice of inju	ury - At not c. <i>(Specify</i>	me, farm, st	reet, tactor	у, опісе			City or	Town, St	ario ivumbe ate)	rornu	rai noute ivan	iber,
_	pital ours a eral I		29a. Certifier	1 Certifyin	g Physician: To t	the best	of my knov	wledge, deat	h occurred	d at the tir	me, date ar	nd place,	and due to t	he cause	e(s) and mai	ner as	stated.	
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only one)	2☐ Medical	Examiner: On the	basis o	f examinat	ion and/or ir	vestigatio	n, in my o	opinion, dea	ath occur	rred at the tin	ne, date	and place, a	nd due	to the cause(	
	To the within some	Me	29b. Signature ar	nd the of cettifie					29	c. Licens	e number			29d.	Date signed	(Monti	h, Day, Year)	_
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2	-16)		30. Name and ad	dress of person	no completed ca	ause of d	eath (Item	23a) (Type,	Print)		ż	n	Λ Λ		C			1/2000
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	Sta Registr		31. Date filed (Mo		who completed ca man 32	Hegistr	ars Signa	ne de										-
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amended item 5/2-11-08/wicohd/map definition of Death

Reg. No. For State Registrar Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician ENDLEY PHILLIPS 30 2008 HABL /Medical 4a. Eacility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HOSMICO PANSUA ALGENIAL Social Security Nonba4 Salisticy Medese Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1**☑** M 2□ F Yrs. Director permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 Is merked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Directo WICOMICO 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2183 USA MHIN Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 945 1 ☐ Yes 2 No Specify. Baltimore, Maryland 21215-0036 Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ARPEN CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be To 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sings Phurs Wife

20a. Method of Disposition

1 Burial 2 Scremation 3 Removal from State 2183 MARIDELA MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee PO BOX 61 HOME MD 21814 EDVO VB 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

\_a. 

Aornc Strnosss Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificete be executed signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2∐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 2 No 1 Yes eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1. Inpatient 1 ☐ Yes 2 ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title 1-31-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Miltors Traush 31. Date filed (Month, Day, Year) egistrar's Signature 32 State FEB 05 Registrar 2008

		1 - For State Registrar	State of Ma		epartm Certific				Reg. No. 2	008	0490
Physi /Med		1. Decedent's Name (First, Middle, Last		SR.				2. Date of De Month 02	0 2	Year <b>2008</b>	3. Time of Death
Exam Funera	iner	4a. Facility Name (If not institution, give UNIVERSITY OF MARY UNI 5. Social Security Number 6. Se	MEDICAL	e (In yrs. last birt	B	ALTIM der 1 Year	r Location of Death  OFF  If Under 24 Hrs.  Hours Min.			9. Birthp Coun	olace (State or Foreig
Directo value of a te be		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location			Mar 6,	1958		Dd. Inside City Limits
th with the M 23a or 28a-f sst be notifile	al Director	MD Frederick 10e. Street and Number 8811 Eureka Lane		Walkers	10f.	Zip Code			10g. Citizen of USA		
ING Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent If Armed Forces? 1 ☐ Yes 2X N If Yes, Give Year or Dates:		1 □ Ye	a <b>X</b> □ No	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No to Rican, etc.)	Spec.	WIIT	etc. te
Z1Z1 ed within ygiene. er than "	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12	ucation de completed) College (1-4or 5	i+)	Decedent's U (Give kind of life. DO NO inter	work done	during most of woi		Constr	uctio	•
should and Mer marke	To Be	17. Father's Name (First, Middle, Last)  Leon Printz  19a. Informant's Name/Relationship (7)	ype. Print)	19b.	Mailing Add	ess (Street	18. Mother's Nar Vergie I  and Number or Re	Bayles			Code)
of Heal		Carol L. Printz/wi 20a. Method of Disposition 1□ Burial 2 □ Cremation 3 □ i 4□ Donation 5 □ Other (Specify	Removal from State	20b. Place of cemeter	Disposition (	Name of or other place	ane Walke ory 02/0	Date	, MD 21 20c. Location Beltsvi	- City or To	,
permit. Page Department c Important: if any injury or	9000	21. Signature of Funeral Service Licens  23a. Part1. Enter the disease, or compshock, or heart failure. List only of	Loute	MO1251 the death. Do note.	Beve	rly L.		te, P.A	. Clark		e, MD 2102 Approximate Interval Between
Physicial /Medica Examine	ıl	Immediate Cause (Final disease or condition resulting in death)	a. HEPAT	O RENAL a consequence of	FAIL of):	ne	***				Onset and Death 21 day 5
ficate be executed physician and sthe burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of		6UN5H	TOT WOV	NO BY MEDICW	EXAMINER		
OLGS, F.O. BOX 06/17 requires that the death certificate tendines that the attending physical point by the attending physical to the bound be detached for use as the the tending be detached for use as the tending by	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectop 5 □ Other	c pregnanc (specify) _	CERTIFICATION APP	ROVE	23d. D	ate of delive	ery Day Year
w requires that the speed by should be detacted by	þ	Part II. Other significant conditions co	entributing to death be	ut not resulting in	the underlying	g cause giv	en in Part I.		tobacco use co Yes 2 No		he cause of death? bably 4 □Unknow
The law ate has b page 2 sh	Completed							1□ Yes	psy ormed? 2 X No	prior to co death?	opsy findings availabl impletion of cause of 2 No
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i gift o	Certification:	35 Suicide 6 Could not be determined	28e. Place of injubuilding, etc.  HOME	ury - At home, far c. <i>(Specify)</i>	m, street, fac	tory, office		28f. Location ( City or To 8811 EUR	Street and Num wn, State) KA LANE	walker	HOT WOUND al Route Number, L'SVILLE, MO.
To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Examone)  29b. Signature and title of certifier	iner: On the best of and manner sta	f examination and		29c. Licens	opinion, death occ		, date and place 29d. Date sign	e, and due to	to the cause(s)
Ja or		30. Name and address of person who co					7163	mD 21		108	

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year) FEB 0 5 2008

Sparke

32. Begistrar's Signature

Division or Vital Records, P.O. Box 68760,

3altimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after deatl To the Funeral Director:

State Registrar

29b. Signature and title of certifier

mpleted cause of death (Item 23a) (Type, Print) Mar bor Hospital

29c. License number KEJ-001 29d. Date signed (Month, Day, Year) January 29, 2008

3061 s. Hanoverst. Battimore MD 21225

32. Resistrar's Signature Day, Year) FEB 0 1 2008

			For	State	of Maryla		artment of			ental Hy	giene	200	0	01.07	J Q
			- State RegistrarAMEND#23a(b		08,BMW,Mb	co Ce	rtificate c	of Death			Reg. No.	200	0	0490	JU
4	Physici	an	Decedent's Name (First, Middle	e, Last)						<ol><li>Date of De Month</li></ol>	Day	Yea		3. Time of Death	
	/Medic	al	William Pollin  4a. Facility Name (If not institution	n give etreet and n	ımher)		4h City Town	n, or Location		January		2008 County of De	ath	5:45 A	
	Examin	er	Suburban Hospi		inber)		Bethes		or Death			ntgome			
4	Funeral		5. Social Security Number	6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Ye	ar If Under		8. Date of Bir	rth	9. B	irthplac	e (State or Fore	ign
и	Director		015-20-3724	1 <b>3</b> M 2 ☐ F	85	Yrs.	Months Da	ys Hours	Min.	(Month, Da May 13	, 192	2 Per	Country, 1nsy	lvania	
	pur »		Usual Residence of Decedent  10a. State 10b. County		10c. C	City. Town or Lo	cation						10d.	Inside City Limi	its
	Maryla f sho led at	jo.	MD Montgo		P.O.	thesda								1 ★ Yes 2 □ N	
	the l	rect	10e. Street and Number	Jillet y	ье	tnesda	10f. Zip Cod	le			10g. Citiz	en of What (	Country	?	
	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	Funeral Director	7716 Sebago Roa	ad			20817	,			II.	S.A.			
	ems deat	ner	11. Marital Status	12. Was De	cedent Ever in	U.S. 13.	Was Decedent of		rigin? (Spe	cify Yes or No		4. Race - Ar Black, Wi			
98	or ite	y Fu	1 Never Married 2 Mar	ried 1 XIYes If Yes, C	aive Mar	ines	1 □ Yes 2 🔯 I			mount, otoly		Specific			
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פָּ	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name	(First, Middle	, Maiden S	Surname)			
<u>la</u>	Menta Menta arked	ToE	Samuel Pollin					Fan	ny Gl	assman	1				
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relations	, , , , ,			ng Address (Str						e, Zip Co	ode)	
	1 and Health em 27 ther t		Teresa A. Poll:	in - Wife	20h		Sebago			sda, M		317 cation - City	or Town	State	
Baltimore,	ages nt of h : <b>if ite</b>		1 ☑ Burial 2 ☐ Cremation		n State		osition (Name of matory or other					•			
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Division or Vital	g Phy er this eral o	n: To	27. Manner of Death	28a. Dat	e of Injury onth, Day Year)	28b. Time o		njury at Nork?		28d. Describe			pecity)		
ion	ath. rr: Aft	atio	Z III Accident	gation	ntn, Day Year)	Injury		Work? 1 ☐ Yes 2 ☐	]No						
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	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical		ng Physician: To the Examiner: On the	basis of exami										
	thin 2 the or the omple	Med	29b. Signature and title of certific		nner stated.		29c. Lic	ense number			29d. Date	e signed (Mo	onth. Da	v. Year)	
	F S F S	_			. 1	7	D262					5/2008			
	12		30. Name and address of person	who completed car	use of death (Ite	em 23a) (Type.		<i></i>			1/23	7/2008			
			Ava A. Kaufman,			, , , , ,	enue B	ethesd:	a, MD	20814					
.75	Sta		31. Date filed (Month, Day, Year,	30	Règistrar's Sig	nature	4								
	Registr	ar	FEB 0 4	2008	we s	The Contract of the Contract o	WED !								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 2, 2008 **Physician** 4:50 P M Maurice Anthony Patterson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's 5827 Fisher Road #201 Temple Hills If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 X M 2 □ F 579-92-4672 34 Feb. 6, 1973 Washington, DC Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notlfied at 1 ☐ Yes 2 📆 🛠 lo Director Temple Hills Prince George's Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or 20748 USA #201 5827 Fisher Road "natural", or items 23a Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes **XX** No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify. Specify: Black Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation th and Mental Hygiene.

7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Mechanic Automobiles 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fil. Health and Mental H tem 27 is marked oth Be Patterson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau 5827 Fisher Road #201 Temple Hills, Maryland Lisa Patterson / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 02/05/2008 Edgewater, Maryland Kalas Crematory 4 ☐ Donation 5 Other (Specify) Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signature 6160 Oxon Hill Road Oxon Hill, Maryland 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 11/n0 Physician 41116 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the 38 IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No ģ 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? cate has been signed I page 2 should be deti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 1□ Yes 2 No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA P After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Certification: 5 ☐ Pending investigation 1XX Natural 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Division or Vital Records,

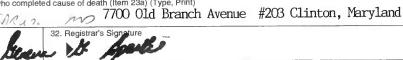
Medical State

31. Date filed (Month, Day, Year) FEB 0 4 2008

6 Chris

(Check only one)

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

P. 00/8613

29d. Date signed (Month, Dav. Year)

20735

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2:25 AM FEBRUARY 7 2008 SYLVIA BENNETT POOLE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** CHARLES CIVISTA MEDICAL CENTER T.A PLATA If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday 5. Social Security Number 6 Sex **Funeral** Months 1 ☐ M 2 🔀 F 74 SEP.19,1933 ENGLAND **Director** 220-28-6900 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County show an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at 1 ☐ Yes 25 No Director MD CHARLES WALDORF 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U. S. A. APT. 112 20602 3605 MOSES WAY Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 35 Wo If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. 11 Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. à 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) marked other than traumatic event, the 9 CAKE DECORATOR WALLS BAKERY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BERNARD BENNETT CECEILA LUPO and f 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra ROSELLA L. EDELEN/DAUGHTER 6837 CARRICO MILL RD. HUGHESVILLE, MD20637 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition FEBRUARY Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MARY'S CH.CEM. 14, 2008 BRYANTOWN, MARYLAND 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 21. Signature of Funeral Service Licensee 5635 WASHINGTON AVE.LA PLATA, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed Cancel burial-trai Due to (or as a consequence of) Box 68760, physician Physician/Medical the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ■ No 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown s been signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death Check onl one 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

Division or Vital Records, Hospital or Attending Physician:

the

funeral director hours after death uneral Director: filled in by within 24 hours at To the Funeral D completely filled in

28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 6 ☐ Could not be 3 ☐ Suicide

28b. Time of

28c. Injury at Work? 1 Yes 2 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) and manner stated 29c. License number 29b. Signature and title D34140

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) as washing tan ABDEL FZ12 EL SAID. 3261 Old washing tan

Registrar

4 Homicide

29a. Certifier

Yea 11:25 AM 2008 4c. County of Death Baltimore of Maryland Medical University of 5. Social Security Number NONE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours 1**∑** M 2□ F 16,1932 **GUYANA** 75 Director 215-11-0896 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County a or 28a-f show t be notified at 1√∑Yes 2 □ No Director PRINCE GEORGES BRENTWOOD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a other traumattc event, the Medical Examiner must be 3708 TILDEN ST. 20722 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Intent of Health and Mental Hygiene. It is marked other than "natural", or ite uny or other traumatic event, the Medical Examine ury or other traumatic event, the Medical Examine. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No þ 3 Widowed 4 Divorced BLACK Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ APPRAISER REAL ESTATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 **EDWARD** QUELCH LILLIAN MOORE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) QUELCH/WIFE 3708 TILDEN ST., BRENTWOOD, MD. 20722 RADICKA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE, MD. CHAMBERS CREMATORY FEB. 6,2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. hambura M00091 20737 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hemerrhagic She Due to (or as aconsequence of): **Physician** Days /Medical **Examiner** End Stage Liver
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Renal Failure law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2□ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed' Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ۵ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury at Work? Certification: 1 Natural 5 Pending Injury 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only within 2. and manner stated. To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 17280 January 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Maryland 21201 22 Greene South Ali Emamhosseini 31. Date filed (Month, Day, Year) FEB 0 5 32 egistrar's Signature State 2008 Registrar

			1 - State amend #5 Per F	State of Maryland / Part G877 3/05/08	Depa <b>Te</b> rt	rtment of He rificate of D	ealth and M Death	ental Hygier Reg. N	Em. () ()	04907
ı	Physicia	an	Decedent's Name (First, Middle, Last)						ay Year	3. Time of Death
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	Funeral Director		5. Social Security Number 6. Sex 1 1	M 2 F 7. Age (In yrs. last bi	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea 07-26-191	9. Bird Co 3 Sou	hplace (State or Foreign untry) th Carolina
	D D		Usual Residence of Decedent  10a, State 10b, County	10c. City, Tow	wn or Loc	ation				10d. Inside City Limits
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	r 28e-	Director	MD Wicomico  10e. Street and Number	Salis	bury	10f. Zip Code		10g. (	Citizen of What Co	puntry?
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	er dea	Funeral	The state of the s	2. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of His Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
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Maryland	2 sho and l		19a. Informant's Name/Relationship (Type Alice E. Redfield					il Route Number, Cit Ve, Olney		
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8760	cate be executed physician and the burial-transit	dical	d							
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Box	death certifi e attending i ed for use as	Iclan/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death		Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
o.	0 0	Physic	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	9 Unknown	3	Other (specify)				
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0 4	ding Ph. h. After thi funeral		27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b.	. Time of Injury	28c. Injury Work		28d. Describe how in	njury occurred	
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	Registi		31. Date filed (Month, Day, Year) FEB 0 5 2	32. Regitrar's Signature	K ,	South				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 27, 2008 2:40 Rodriguez January Antonio /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Rockville Montgomery Shady Grove Adventist Hospital Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex Days **Funeral** 1 🔀 M 2 🗆 F 1940 Puerto Rico 67 June 18, Director 012-32-3248 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10b. County 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 TyYes 2 □ No Director Maryland | Montgomery Germantown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20874 United States 12915 Poppyseed Court Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Black, White, etc. 1 ☐ Never Married 2 ☑ Married Specify: Puerto Rican Specify: Caucasian altimore, Maryland 21215-0036 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: ģ 3 ☐ Widowed 4 ☐ Divorced 'natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Representative Health and Mental Hygi em 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Manuelita Rodriguez Eduardo Rodriguez 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12915 Poppyseed Court, Germantown, MD 20874 Carolina Rodriguez / Spouse permit. Pages 1 an Department of Heal Important: If Item 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Lincoln Crematory 1/31/2008 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Ft. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the di eas shock, or hi art fail ure , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate are (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): **Examiner** Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease on injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death I Yes 2 □ No the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No this certificate has 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA 2**⋈** № 1 ☐ Yes 1 Inpatient 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 5 Pending investigation 1 🔀 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, completely filled in by the funeral director, page 2 should hin 24 hours after death the Funeral Director:

Certification: To

Medical

To the within ? To the

State

Registrar

31. Date filed (Month, Day, Year) FEB 05

2008

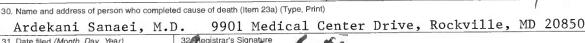
29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)



32 Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-00834 State of Maryland / Department of Health and Mental Hygiene 2008 04909 Mary Rhea 1- For State Certificate of Death Reg. No Registrar Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day January 30, 2008 0815 hrs Rhea Elizabeth Mary Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring 3214 Norbeck Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreig Pennsylvani 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex **Funeral** Months Days Hours Director 82 Apr.19 2 X F 1925 579-24-4506 М Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 X No permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3214 Norbeck Road 20906 USA 靣 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 2 X No Yes White Yes 2 X No specify: Specify: If Yes. Give Yea 3 X Widowed Divorced þ or Dates 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) MD 21215-0036 Homemaker Own Home 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Warren Shook 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 8925 Peoria Court, Springfield, Va. 22153 Jacqueline R. <u>Rodgers/Daughter</u> 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State /2/08 <u>Falls Church, Va.</u> National Mem. Park Other Specify Donation 5 22. Name and Address of Facility 171 W.Maple Ave. Signature of Euneral Service Licensee Vienna, Va. M00968 Money & King Funeral Home, Inc, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line. /Medical a. Hypertensive Cardiovascular Disease complicated by Entrapment Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical tending physician a UNPENDED AMENDED Box 68760 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy . Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) ō Yes 2 V No 9 Unknown q Unknown the 8 detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o Yes 2 ✔ No 3 Probably 4 Unknown Completed by ے Dementia Records, 24b. Were autopsy findings available 24a Was an peen prior to completion of cause of autopsy has performed? death? 2 No ✓ Yes 2 No 1 🗸 Yes After this certificate 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other: Hospital: Residence 6 V Other: Scene FR/Outpatient 3 Nursing Home 5 Inpatient 2 1 V Yes Certification: To 28a. Date of Injury FOUND: 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred 27. Manner of Death Trapped between mattress and bed rail FOUND: Natural Yes 2 V No Pendina within 24 hours after death. To the Funeral Director: completely filled in by the Jan 30, 2008 0745 hrs 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State) 3214 Norbeck Road, Silver Spring, MD Suicide (Specify) Other (specify) Homicid 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

State

Registrar

10

. Registrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

January 31, 2008

30. Name and address of person who completed cause of death (Item 23a)

0 5 2008

Carol Allan, MD

31. Date filed (Month,

Assistant Medical Examiner

04910

3. Time of Death

2:30 P M

Exami		4a. Facility Name (If not institution, g Charlotte Hall		_	4b. City, Town, or Charlott	Location of Death			y of Death Mary s
Funeral Director		218-20-1883	Sex   7. Age (In yrs. 1	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Jan 20	1925	9. Birthplace (State or Foreign Maryland
pus		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. inside City Limits
larylan show ed at	2	Maryland Calver		Leona					1 ☐ Yes 2 No
the M 28a-f notifie	Director		51.	Leona			1	Og Citizen of	What Country?
ath with t		10e. Street and Number 1612 AVE. D			10f. Zip Code 20685				What Country? States
ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces?  1		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- o Rican, etc.)	Bla	ace - American Indian, ack, White, etc. ify.white
2 hou atura cal E		15. Decedent's	Education	16a, Dece	dent's Usual Occup	ation		16b. Kind of E	Business/Industry
within 7; iene. than "n the Medi	Completed	(Specify only highest g	Collegge (1-4or 5+)	field	kind of work done of DO NOT use retired engineer	during most of work 1) -	ang	resear	ch and developme
2 should be filed value and Mental Hygier Is marked other raumatic event, tt	To Be C	17. Father's Name (First, Middle, La Theodore A. Ric	ketts, Sr.			18. Mother's Nam Edwinna	e (First, Middle, I Benson	Maiden Surna	ime)
ind 2 should aith and Mer 27 Is marke	-	Dorigate Nane/Relationship	(Type. Print)	1861M2***	AVE D'Stet	and Number of And	raMD#21968	5 <sup>City</sup> or Town	n, State, Zip Code)
Pages 1 annent of Herant: If Item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	□Removal from State Met	ropoli	osition (Name of The Punet Can Funet	al servi	<sup>©</sup> 2008 A	lexand	- City or Town, State ria Virginia
permit. Page Department ( Important: If any injury or		21. Signature of Funeral Service Lice	rensee	442	2. Name and Addres 05 Broome	es Is. Rd	usch Fun . Port R	eral Ho epublio	ome c MD 20676
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	implications that caused the deat	h. Do not ent	ter the mode of dyin	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between
Physician	n i	Immediate Cause (Final disease or condition	62100	2	C500	BROUR C			Onset and Death
/Medical		resulting in death)	Due to (or as a conseq	uence of):		DAVID C	ULAR VIC	-Killy	
Examiner			b. WIT	# Fan	1 URS TO	3 there	9		
	ner	if any, leading to immediate	Due to (or as a conseq	uence of):					
cuted nd ransi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	с	DRON	JARY AR	zarey 1	DISTASS	7 .	
an ar		resulting in death) Last	Due to (or as a conseq	uence of):	110				
cate be executed physician and the burial-transit	lical	•	d		Hyraz	TENSLY	v'		
e as i	Mec	IF FEMALE: N/A							
w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of continuous 9 ☐ Unknown	ıl death 3[	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>	/			ate of delivery Month Day Year
_ ⇒ ŏ⊽		Part II. Other significant conditions	s contributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use cor	ntribute to the cause of death?
uires sign Id be	d by	0108578	& MELLITUS				1 □ Y	es 2□ No	3 Probably 4 Unknown
v req been shoul	ete						24a. Was a	24h	. Were autopsy findings available
2 8 2	ompleted						autops perfor	med?	prior to completion of cause of death?
	O	25. Was case referred to medical				26 Place of Dec	1  Yes th (Check only on		1 ☐ Yes 2 ☐ No
/sicia	o Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1   Inpatient 2	EB/Outpatier	nt 3 DOA Oth	or:	ome 5 ☐ Reside		ther (Checiful
Attending Physician: r death. ector: After this certifice by the funeral director, I	1-	27. Manner of Death	28a. Date of Injury	28b. Time o			28d. Describe h		
nding Path.	ioite	1 ∰Natural 5 □ Pending 2 □ Accident investigat	(Month, Day Year)	Injury		Yes 2 □ No			
al or Atte s after des il Directo	Certification:	3 Suicide 6 Could not 4 Homicide determine		ome, farm, sti	reet, factory, office		28f. Location (S. City or Town		nber or Rural Route Number,
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (		Physician: To the best of my know aminer: On the basis of examina and manner stated.						
To the within To the Comp	Me	29b. Signature and title of certifier	) , 0		29c. Licens	e number	2	29d. Date sign	ned (Month, Day, Year)
		· m	(lav)		D	00567	52	02	104/2000
12		30. Name and address of person wh	no completed cause of death (Iter	n 23a) (Type,	Print)	00/0/		1	HARLOTTE
1 9		NA7-N	IN ESPIANI.	M	29449	CHARLOT	TE HALL	-RD,	HALL, MD 2062
	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature					
Regis	trar	FEB 6 200	De procesa, De	Spare					

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 12:48 a M Angel Reantoquio 02/01/2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Citizen Care and Rehab Center Frederick Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday. Date of Birth (Month, Day, Year) **Funeral** Days 1**½** M 2□ F Director 109-16-7790 90 10/17/1917 Philippines Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? IISA 1900 Rosemont Ave 21702 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Ves 2 No 1937 – If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 r than "natural", or the Medical Exami 1 ☐ Yes 2√2 No Specify: þ Asian 3 ₩ Widowed 4 Divorced Year or Dates: 1939 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) filed within 7.
I Hygiene.
other than "n Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Pilot and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fi of Health and Mental H 'item 27 Is marked oth Be Foston Reantoquio ပ Auloha Aba 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1601 Roam Ct, Owings, MD 20736 Kenneth Reantoquio / son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If itel
any Injury or ott 1 → Burial 2 □ Cremation 3 □ Removal from State Ft. Lincoln Cemetery 02/05/2008 | Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Lice 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumonia DAYS **Physician** disease or condition resulting in death) /Medical 8 bilivactive Palmonary disease YEARS Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exam and Due to (or as a consequence of) burial-t P.O. Box 68760. attending physician certificate be Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ō in the past 12 months? Day 5 ☐ Other (specify) ☐Yes 2☐No detached the 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 2 1No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Thursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3□ D**O**A 2 After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 □ Pending Injury To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A investigation 1 TYes 2 TNo death. 2 Accident the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D006 L22 3 30. Name and address of person who completed cause of death (item 23a) (Type, Print) BELAQUM, MD, 196TJ DLIVE, FREDERICE, MD -2/703.

32. Registrar's Signature. PRACEGN 31. Date filed (Month, Day, Year) 7 2008 Registrar

		1	For State Registrar	State o	f Maryland		rtment tificate			ind M		giene Reg. No	7 H H X	04912
	Physici	an	1. Decedent's Name (First, Middle, I Paul Frank Rodan	,							2. Date of De Month Jan	ath Da	2008	3. Time of Death 7:00 PM
	/Medio Examir		4a. Facility Name (If not institution, g Genesis Healt	ive street and nu	- The I			Ea	Location o	1			County of Deat	ot
	Funeral Director		578-56-6745	Sex 1 M 2 □ F	7. Age (In yrs. la	ast birthday) Yrs.	If Under	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da 02/11/	194.	9. Birt Go Wash	hplace (State or Foreign ountry) nington, DC
	with the Maryland a or 28a-f show be notified at	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Talbot			Town or Lo								10d. Inside City Limits 1 X Yes 2 □ No
L	an with the 3a or 28s st be noti	Dire	10e. Street and Number 29670 Janet's Wa		-1		10f. Zip	<sup>Code</sup> 2160	)1				itizen of What Co USA	ountry?
)36 K	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dec	ive	1	Was Deced f Yes, spec 1 ☐ Yes 2			gin? (Spe i, Puerto l	cify Yes or No Rican, etc.)	)-	14. Race - Ame Black, Whit Specify: Wh	
215-0(	within 72 hou lene. than "natura he Medical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (		(Give life. I	dent's Usua kind of wor DO NOT us	k done d e retired	ation furing mosi )	t of workii	ng	//-	Construc	·
Rodano Maryland 21215-0036	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If Item 27 is marked other than any injury or other traumatic event, the Meone.	Be	17. Father's Name (First, Middle, La Paul Frank Roda	•		F.T.E	ectric	ian			(First, Middle	, Maidei		
Rodano <b>Maryland</b>	nd 2 should Ith and Me 27 is mark * traumatio	2	19a. Informant's Name/Relationship  Janice Rodano/Wi	(Type. Print)			•		and Numbe	er or Rura		er, City	or Town, State, .	Zip Code)
Paul Baltimore,	Pages 1 ar ent of Hea nt: If Item ? ry or other		20a. Method of Disposition  1 ☐ Burial 2 🖸 Cremation 3  4 ☐ Donation 5 ☐ Other (Spe	□Removal from	20b. P	Place of Disponentery, crash					ate	20c. L	ocation - City or bridge,	
P Baltir	permit. Departm Importa any Inju		21. Signature of Funeral Service Li	en-1/2	ance								ambridge	e,MD 21613
	Physician		23a Part 1. Enter the disease, or c shock, or heart ratture. List o Immediate Cause (Final disease or condition	niv one cause on	caused the death each line.		_		g, such as	cardiac o	or respiratory a	arrest,		Approximate Interval Between Onset and Death
٦	/Medical Examiner	<u>.</u>	resulting in death)  Sequentially list conditions, if any, leading to immediate	b	(or as a consequence of or a consequence of or as a consequence of or as a consequence of or a consequence or a con									
-	ite be executed ysician and ne burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с	o (or as a consequ									
68760,	e % e	ical	TE SERVICE	d										
O. Box	The law requires that the death certifica ate has been signed by the attending phage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐Live	utcome pf pregna birth 2 □ Feta gnant at time of d nown	aldeath 3[	⊒Ectopic pr ⊒ Other <i>(sp</i>		/				23d. Date of de Month	elivery Day Year
rds, P.	w requires that t s been signed by should be detact		Part II. Other significant condition		death but not res	ulting in the u	inderlying c	ause giv	en in Part I	l.	10			to the cause of death?  Probably 4 Unknown
I Reco	The law re ate has bee page 2 sho	Completed by	,								24a. Wa: auto peri 1∐ Yes	opsy formed?	prior to death?	
or Vita	physician: The la this certificate ha al director, page 2	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death		Inpatient 2	ER/Outpatie			er: 4 N		me 5 ☐ Res 28d. Describe	sidence	6 □Other (Sp	ecify)
Division or Vital Records, P.O	tending I leath. tor: After the funer	Certification:	2/1. Manner of Death    Matural   5   Pending investigate	(Mo	ce of injury - At hidding, etc. (Special	Injury ome, farm, st	M		yai k? Yes 2 □			(Street	and Number or F	Rural Route Number,
	Hospita 4 hours Funera tely fille	Medical Ce	29a. Certifier Certifying (Check only one)	Physician: To the xaminer: On the and ma	he best of my kno basis of examina anner stated.	owledge, dea ation and/or i	th occurred	at the ti	me, date a opinion, de	nd place, ath occur	and due to the	e cause e, date a	(s) and manner and place, and di	as stated. ue to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	Men	by NO		29	c. Licens	pzs	93	3	29d. D	Date signed (Mod	
	5		30. Name and address of person w	who completed can	use of death (Iter		Print)	NS	LAN	ارک	E	AST	ON, MI	21601
	Si Regis	tate trar	31. Date filed (Month, Day, Year)	4 2008	Restrar's Sign	ature	And	ما					*	

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland			ental Hygi	ene <sub>2008</sub>	01.913
		_	Registrar	Certificate of	Death		g. No U U (	04710
	Physici	an	1. Decedent's Name (First, Middle, Last)			Date of Death     Month	Day Year	3. Time of Death
	/Media		Grace Emily Reynolds  4a. Facility Name (If not institution, give street and number)	4h City Town o	r Location of Death	Februar	y 3, 2008 4c. County of Dea	05:40 AM
	Examir	ier	Calvert Manor Healthcare Center	Rising				u)
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Cecil 9. Bir	thplace (State or Foreign
	Director		217-22-4109   ¹□M 2⊠F   87	Yrs. Months Days	Hours Min.	(Month, Day, July 12		ountry) cyland
	pu »		Usual Residence of Decedent  10a. State 10b. County 10c. City, To	own or Location				10d. Inside City Limits
	shov shov	'n		th East				1√GYes 2 □ No
	the N 28a-f	Director	10e. Street and Number	10f. Zip Code		10	g. Citizen of What Co	****
	aa or	Ö	16 Rolling Mill Lane	21901	ı			,
	ms 2:	Funeral	11. Manital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of H	ispanic Origin? (Spe	cify Yes or No-	Jnited Sta 14. Race - Ame	erican Indian,
9	or ite		1XXIvever Married 2 Married Armed Forces?  1		an, Mexican, Puèrto I	Rican, etc.)	Black, Whi	
21215-0036	ural",	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2√√No	Specify:		Specify: Wh	ite
<u>2</u>	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	<ol> <li>Decedent's Usual Occup (Give kind of work done)</li> </ol>	during most of working	ng 1	6b. Kind of Business	/Industry
12	withir ene. than	E G	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired	3)		Restarau	nt
о О	e filed within 72 hours after death with the Maryland at Pygiene. other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at		17. Father's Name (First, Middle, Last)	Waitress	18. Mother's Name	(First, Middle, M	aiden Surname)	
au	lid be lental ked c	To Be	Melvin L. Reynolds	Si di	Helen E	. Lockaı	-d	
Maryland	2 should be f and Mental I is marked of raumatic ever	-	19a. Informant's Name/Relationship (Type. Print)	9b. Mailing Address (Street				Zip Code)
	1 and 2 Health a iem 27 is		E. Sherry Jackson / Sister	40 Fire Tower	Road, Po	rt Depos	sit, Maryl	and 21904
altimore,	r in		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State	e of Disposition (Name of etery, crematory or other place	e) Febr	uary 2	0c. Location - City or	Town, State
Ē	. Pag tment tant: I		4 □ Donation 5 □ Other (Specify) Nort	h East Method			North East	, Maryland
Bai	permit. Pag Department Important: I: any Injury o		21. Signature of the mi Service Livenie	22. Name and Addre				
	ED = 6 0		23a. Part1. Enter the disease, or complications that caused the death. D			*****		aryland21901
b	A. P		shock, or heart failure. List only one cause on each line.	oo not enter the mode or dyir	ig, such as cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  a.   At the first and the first are a consequence of the consequence of the first are a consequence of the consequence of the consequence of the		Waton +	BILOR		61 Week
	Examiner			,				116000
		je.	Sequentially list conditions, if ally, leading to immediate	ce of):	0.0			~77°04(č
	cuted nd ransit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	rtery dyces	د			chronic
, 0	ie exe iian al urial-1	EX	resulting in death) Last  Due to (or as a consequence	ce of):				
38760,	icate be executed physician and s the burial-transit	dical	d					
~	certific ding p	/Me	IF FEMALE: 23b. Was deceded program 23c. If yes, outcome pf pregnancy					
Box	death certifi e attending d for use as	cian	in the past 12 months?	ath 3 ☐ Ectopic pregnancy	1		23d. Date of de Month	livery Day Year
o.	0 0 0	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown	Totaler (specify)				
о_	s that ned b e deta	by Pr	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause give	en in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
rds	w requires been signe should be	g p	Periphal Vascular disease			1 ☐ Yes	s 2 <b>00/N</b> o 3□P	robably 4 □Unknown
Vital Records,	The law requires that the tee has been signed by th sage 2 should be detache	Completed	Mitral regurgitation			24a. Was an	24b. Were a	utopsy findings available completion of cause of
ř		mo	3			autopsy perform 1 Yes 2	e prior to death?	
/Ita	clan: ertifica	Be C	25. Was case referred to medical examiner?		26. Place of Death			
2	Physic rthis o	은	1 ☐ Yes 21 No Hospital: 1 ☐ Impatient 2 ☐ ER/	Outpatient 3 DOA Oth	4   Nursing Hor		nce 6 Other (Spe	ecify)
Division or	Ilng F	ion:	1 Matural 5 Pending (Month, Day Year)	b. Time of 28c. Injury Worl		28d. Describe how	v injury occurred	
<u>S</u>	death death ctor: y the	icat	Accident investigation  3 Suicide 6 Could not be determined 28e. Place of injury - At home,		Yes 2 □ No	Rf Location (Str	eet and Number or R	ural Poute Number
2	after after Dire	Certification:	4 Homicide determined building, etc. (Specify)	iam, sa sea, rasery, emoc	1	City or Town,	State)	arar House Number,
	spita hours unera y fille	a C	29a. Certifier 1 Certifying Physician: To the best of my knowled	dge, death occurred at the tir	ne, date and place, a	and due to the ca	use(s) and manner a	s stated.
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, it	ledical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or investigation, in my o	pinion, death occurr	ed at the time, da	te and place, and du	e to the cause(s)
	Veith of the property of the p	Σ	29b. Signature and title of certifier	29c. Licens			d. Date signed (Mon	
)	ا ہر ا		30. Name and address of person who completed cause of death (Item 23a  Alfred A Pins Un Medical Drive  31. Date filed (Month Pay Year)  32. Registrar's Signature	D 00.	11/90	F	e Grany 7,	CO08
	5		30. Name and address of person who completed cause of death (Item 23a	a) (Type, Print)	14 15	781 To1	10 A 11 D	17.00
	Sta	te.	31. Date filed (Month, Day, Year) 32. Registrar's Signature	TOY CAIDE	V7945 16	101 / 5/6	4 rajis 120	1 KOR JUL MI
	Registr		31. Date filed (Month, Day, Year)	barle				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1- State Registrar Amend Item 24a, b per dr., g877	artment of Health and N 03/07/08-bb ruffcate of Beath	/lental Hygie Reg.	ne No.2008	04914
y	Physicia	an	1. Decedent's Name <i>(First, Middle, Last)</i> Julius Lawrence Rogers		2. Date of Death Month /29/		3. Time of Death 1:10pmM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1/25/	4c. County of Deat	
			6037 Drum Point Rd.	Deale		Anne Aru	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 216-16-4221 85 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, You 2/24/192	9. Birt 2 Ma	hplace (State or Foreign untry) ryland
	nyland how at		10a. State 10b. County 10c. City, Town or Li	ocation			10d. Inside City Limits
	he Ma 28a-f s	ecto	MD Anne Arundel Deale	106 75- 0-1-	100	Citizen of Miles Co	1 ☐ Yes 2 ☑ No
	th with t 23a or 2 ust be n	Funeral Director	10e. Street and Number 6037 Drum Point Rd.	10f. Zip Code 20751	109	. Citizen of What Co USA	uniry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 15/CTY es 2 ☐ No WWTT	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 沒☐ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
5-0	"natur	Completed	15. Decedent's Education (Specify only highest grade completed) (Give	dent's Usual Occupation Kind of work done during most of work DO NOT use retired)	ting 16	b. Kind of Business/	Industry
212	withir jiene.	omp	Elementary/Secondary (0-12)   College (1-4or 5+)	ctroplater	1	Metal Pla	ting
and	d be filed antal Hyg ed othe event,	Be	17. Father's Name (First, Middle, Last) John H. Rogers		e (First, Middle, Ma O. Phipp	•	
aryl	should be f and Mental F s marked of umatic ever	L <sub>O</sub>		ng Address (Street and Number or Rui			Zip Code)
Z '6	and 2 lealth a m 27 ls				eale, MD		
nore	ages 1 ant of F tt: If Ite y or ot		20a. Method of Disposition  1 △ Burial 2 □ Cremation 3 □ Removal from State  4 □ Anation 5 □ Other (Specify)  20b. Place of Disposition cemetery, cre  Lakemont	matory or other place)	-	c. Location - City or vidsonvil	
Baltimore, Maryland 21215-0036	permit. F Departme Importan any Injur		21. Signature of Furniral Service Licensee 2	2. Name and Address of Facility Ha		neral Hom	
I CAN PARTY	Physician /Medical Examiner		23/. Part1. Efter he disease, or complications that caused the death. Do not en s bck, or h art failure. List only one cause on each line.  It med ate aus (Final dileas or condition refullying in each)  a.   Due to (or as a consequence of):  Sequentially list conditions,	ter the mode of dying, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
	ocuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause United Section 1 in the International Cause College of Figury that initiated events c.				
68760,	tificate be executed g physician and as the burial-transit	edical Ex	resulting in death) Last  Due to (or as a consequence of):  d.				
P.O. Box 6	± 0 €	Completed by Physician/Mec		□Ectopic pregnancy □ Other <i>(specify)</i>		23d. Date of del Month	ivery Day Year
ds, P	law requires that the de as Leen signed by the a 2 should be detached	d by Pf	Part II. Other significant conditions contributing to death but not resulting in the L	inderlying cause given in Part I.		cco use contribute to	o the cause of death?
Recol	stctan: The law requirectific te has leen rector, age 2 chould	omplete	0 1		24a. Was an autopsy performe 1□ Yes 2 2	prior to death?	utopsy findings available completion of cause of
Vita	certifica	Be	25. Was case referred to medical examiner?		h (Check only one)	12.00	
0	Physical direction	2	1		ome 5 Residence	e 6 Other (Spe	cify)
Division or Vital Records,	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Funeral Director: After this certificate has I een signed by the attendin completely filled in by the funeral director, age 2 should be detached for use	Certification:	1 DNatural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation 3 □ Suicide 4 □ Homicide determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	M 1 Yes 2 No	28f. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
_	To the Hospital within 24 hours a To the Funeral I completely filled	Medical Co	29a. Certifier (Check only one)  1   Certifying Physician: To the best of my knowledge, dear 2   Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, overstigation, in my opinion, death occur	and due to the cau rred at the time, date	se(s) and manner as e and place, and due	s stated. e to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	29c. License number		. Date signed (Mont	-
)			Wayne Do Benkermym	1038563	8	19 31, 200	3'
5	ICH	-		owensule Rel	West	River )	wo
*	Sta Registr	11	FEB 0 1 2008	rade			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 11:43 a M William Samuel Ruby February 6, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 601 Burton Manor Apt. 402 Harford Aberdeen 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 **∑**M 2 □ F Yrs 1/12/1934 Director Pennsylvania <u> 212-26-6328</u> Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural; or Itema 23a or 28a-1 ehow any injury or other traumatic event, the Medical Exeminer must be notified at once. 10a. State 10b. County 10c. City, Town or Location tXX es 2 ☐ No 0 11431 Director MD Harrford Aberdeen 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 74 U.S.A. 601 Burton Manor Apt. 402 21001 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self employed Store 21 11 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Samuel Ruby Elizabeth Baker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 773 Custis St. 21001 John O. Hall, Jr. (Grandson) Aberdeen, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Harford Mem. Gdns. 2/11/08 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funral 6 ... e Licen 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part1. Enter the disease. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) arterio soleroleo Carolio Voscular descose Priysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and that initiated events resulting in death) Last physician ar s the burial-t Due to (or as a consequence of): Box 68760. Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year for in the past 12 months?
1 Yes 2 No Month 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐ Yes 2X No certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After t Certification: To the Hospital or Attending 1 Natural 5 Pending after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral D cal 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 1/2001

BERNARD

31. Date filed (Month, Day,

1614 CHYRCHVINE Rd BELAIR Md 21015

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Selection .

YUKNA MO

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 U U 8 2. Date of Death 1. Decedent's Name (First, Middle, Last) 29 200 g Month **Physician** Sanuary Michael John Seiler, Sr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner EASTON Memorial Hospital TAIbot If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1√2 M 2 □ F 82 213-22-6132 Director December 30, 1925 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Item s 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County пs 23a or 28a-f show 1 ☐ Yes 2√ No Director Maryland Caroline Denton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 25739 Sennett Road Funeral 21629 States of America Race - American Indian, Black, White, etc. United 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☑ Married Specify: Caucasian Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael Jacob Seiler ဥ Emma Mugenthaler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau once. 25739 Sennett Road, Denton, Maryland 21629

20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Julia P. Seiler 20a. Method of Disposition MD constern cremator of other place)
Veterans' Cemeteru 12 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/1/2008 Beulah, Maruland Moore Funeral Home, P.A. 21. Signature of Funeral Service Livense 1000 South Second Street, Denton, Maryland 21629 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 12 YEARS CORONARY **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, board to minious cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To After this 27. Manner of Death

1. Natural

2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the nosposs are death.

To the Funeral Director: A' 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Daye signed (Month, Day, Year) 29b. Signature and title of 00538/5 30/2008 address of permit who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Korah Pulimood,

JAN 3 1 2008

31. Date filed (Month, Day, Year)

M. D.,

32. Registrar's Signature

912 Market Street, Denton, Maryland 21629

A let

Seiler,

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 26, Mary Frances Steward 2008 lanuary /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 11665 Knife Box Road Greensboro Caroline If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 № 2 F 218-20-8442 84 Director Maryland November 27, 1923 Usual Residence of Decedent 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f shov notified at 1 ☐ Yes 2 ☑ No Directo Caroline Maryland Greenshoro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Exa<u>miner must be r</u> 11665 Knile Box Road 21639 United States of America Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ½No f Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Š Caucasian 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 HS Grad Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Pages 1 and 2 should be Frederick Andrew Werner Frances Elizabeth Kerigen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) G. Arthur Steward 333 Cedar Church Road, Harrington, Delaware 19952 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Denton Cemetery 1/31/2008 Denton, Maryland 22. Name and Address of Eacility Moore Funeral Home, P.A. permit. 21. Signature of Funeral Service Licent Haudofal !! one South Second Street, Denton, Maryland 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** EREBILO VASCULAR ACCIDENT CUTE /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed lenoscleratic CARDIOVASCULAR DISEATE attending physician and for use as the burial-tran P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year certificate has been signed by the a rector, page 2 should be detached 2 No 9☐Unknown 9 Unknown Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ₺ Residence 6 ☐ Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury

Division or Vital Records, or Attending Physician: After this within 24 hours after death

To the Funeral Director: a Hospital To the I

5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DEPUCY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christian E. Jensen, 31. Date filed (Month, Day, Year) M.D. PO Bo 32. Degistrar's Signature PO Box 690. Denton, Maryland

State Registrar

FEB 0.1 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

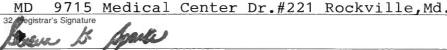
State of Maryland / Department of Health and Mental Hygiene 1000

		State     Registrar  1. Decedent's Name (First, Middle, Last)		Ce	rtificate of	Death	2. Date of Dea	Reg. No.	3. Time of Death
Physic		Gwynne Burban	ck Swart	7			Month	Day	Year
/Medi Examir		4a. Facility Name (If not institution, give st			4b. City, Town, o	r Location of De		4c. County	
		Renaissance Gardens at	Riderwood Vi	llage	Silver	Spring		Pr	ince George's
Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days		lin. (Month, Day	r, Year)	Birthplace (State or Foreign Country)
Director		131-10-9825 Usual Residence of Decedent		89 Yrs.			Nov. 9,	1918	New York
Mon		10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits
a-f si	ctor	Maryland Mo:	ntgomery	Sil	ver Sprin	α			1 ☐ Yes 2 € No
or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Country?
iene. r than "natural", or Items 23a or 28a-f show If at Medical Examir at mant ke notified at		3128 Gracefield				20904		USA	
tural, or item	Funerai	11. Marital Status 1. Never Married 2 Married 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	<ol> <li>Was Decedent Ever Armed Forces?</li> <li>1 ☐ Yes 2 ☑ No</li> </ol>	in U.S.   13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or No- serto Rican, etc.)	14. Raci Blac	e - American Indian, k, White, etc.
al, or	by	3 Widowed 4 Divorced	Il Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:		Specify	"White
natur lical	Completed	15. Decedent's Education (Specify only highest grade	ation		dent's Usual Occup		artina	16b. Kind of Bu	usiness/Industry
ene. than na he Medic	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	during most of di	working		
Hygier Ither It		17 Fatharia Nama /First Middle / and	5+		Physi				nment Contracto
e do	Be	17. Father's Name (First, Middle, Last)  Fred O. Swartz					Name (First, Middle,		(9)
is marked of	2	19a. Informant's Name/Relationship (Typ	e Print)	19h Mailir	on Address (Street		E. Burba Rural Route Numbe		State Zin Code)
nm 27 is nm 27 is her trau		Deborah A. Hathway	•						ville, MD 20850
If itam 27 is marks or other traumatic		20a. Method of Disposition		Ob. Place of Dispo		1	b. 5,		City or Town, State
int: If		1 ☐ Burial 2 反 Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)			itan Crem	.	2008	Alex	andria, Virginia
Important: If ita any Injury or of once.		21. Signature of Funeral Service Licenses		22	2. Name and Addre	ss of Facility			100
2 = 2 9		23a. Paul. Eyler the disease, or complic	195	50	00 Univer	sity Bl	s Funeral	lver Sp	nc. ring, Md 20901
physician and street street transit transit street	dicai Examiner	disease or condition resulting in death)  Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a co	nsaquenna of):	in hy H	vi y			
or use a:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)	1		23d. Dat Mor	e of delivery nth Day Year
signed by the a Id be detached f	by	Part II. Other significant conditions conti	ributing to death but no	ot resulting in the u	nderlying cause giv	en in Part I.			ribute to the cause of death?  3 ☐ Probably 4 ☑Unknown
should b	iete				-		24a. Was a		Vere autopsy findings available
certificate has t lirector, page 2 s	e Completed						- autop: perfor	med?	refer autopsy findings available prior to completion of cause of leath?  Yes 2 No
is certific director,	o Be	25. Was case referred to medical examiner?  1 \( \text{Yes} \) Yes \( 2\sqrt{Q} \) No	ospital:	2 ER/Outpatier	nt 3 DOA Oth	00	Death (Check only or		
	n:T	27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Time of			g Home 5 Resid		
oe fur	atio	1. Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day 16	a <i>r)</i> Injury		K? Yes 2 □ No			
ad in by th	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, str pecify)	reet, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rural Route Number,
10	edical (	29a. Certifier (Check only one) 12 Certifying Physical Certifier 2 Medical Examine	cian: To the best of my er: On the basis of exa and manner stated.	y knowledge, death mination and/or in	h occurred at the tin vestigation, in my o	ne, date and pla pinion, death o	ace, and due to the c ccurred at the time, c	ause(s) and ma date and place, a	nner as stated. and due to the cause(s)
he Fun oletely	M	29b. Signature and title of certifier	人		29c. Licens				i (Month, Day, Year)
To the Fun completely	-				1.50			1	
To the Fun completely			<u> </u>		1000	4566	,	2/4/0	8
within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral		30. Name and address of person who comes that Bhogaville	npleted cause of death	(Item 23a) (Type,	Print)	74366		2/4/0	1, 002-102

Registrar

Joseph

31. Date filed (Month, Day, Year)



MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kaplan

D 35635

Feb.4,2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Yea **Physician** 5:63 PM CHARLES, O, STEWART 30 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner niversi 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/11/1943 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral 1** M 2□ F Hours Min Days Yrs. 64 Director Washington DC 213-42**-**8017 Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 □ No Directo Maryland Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8851 Heathermore Blvd Apt. 104 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bace - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🛣 No Specify ģ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland 12 Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Percy Stewart Mary 2 Savoy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 19a. Informant's Name/Relationship (Type. Print) 8851 Heathermore Blvd. Upper Marlboro, Maryland Betty Stewart / Wife 20c. Location - City or Town, State Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Thomas Church 2/7/08 Upper Marlboro, 21. Signature of Fargeral Service Licensee 22. Name and Address of Facility Adams Funeral Home PA 20605 Aguasco Rd. Aguasco, Maryland 20608 191 23a. 711. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Haute liver /Medical Due to (or as a consequence of): 1.5 Examiner te Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last on CWONIE Due to for as a consequence of Examiner The law requires that the death certificate be executed orgulo pathe burial-tran and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9∏Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has performed2 1☐ Yes 2☑No Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 € No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29b. Signature and title of ertifier 29d. Date signed (Month, Day, Year)

8016

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State Registrar PASIHA ALI, MD
31. Date filed (Month, Day, Year)
32. Resistrar's Sign

FEB 05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Registrar's Signature & South

MD

AU4176435A18123

Baltimore

30/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year 8020 erek 02 50 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cherles La Plate ivist Medical Center If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1**∑**M 2□F Director 217-68-7249 51 29, 1956 WASHINGTON, DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Directo MD CHARLES INDIAN HEAD 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 5425 MASON SPRING ROAD 20640 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 🚻 No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PLUMBER PLUMBING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOSEPH A. SMITH HANNAH C. SIMMONS SMITH ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HANNAH SMITH/MOTHER 5425 MASON SPRING ROAD, INDIAN HEAD, MD 20640 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State ST. CHARLES CEMETERY FEB 8, 2008 GLYMONT, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service I censes THORNTON FUNERAL HOME, P.A. TIDIA C. THORNTON JOHNSON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Caused (First) Approximate Interval Between Onset and Death Immediate Cause (Final HASCUD **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 autopsy rmea ≠ 2 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ▼ER/Outpatient 3 DOA P 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

when D

DHMH 17 Rev 1/2001

Grenn Burns, MD

East

701

32. Reistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEB 0 5 2008

29c. License number

064924

Charles St, PO Box 1040 La Plate

29d. Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar	State of	Maryland	d / Depa	artment rtificate	of Hea	ilth and M	lental Hy	giene. Reg. No.	2008	04922
Physici /Medio	cal	1. Decedent's Name (First, Middle,  Alice  4a. Facility Name (If not institution,	E				VOY	cation of Death	2. Date of De Month	Day	Year 200	
Examin Funeral Director		Fort Washingt 5. Social Security Number 216-90-0547	on Hosp		ast birthday) Yrs.	For	t Wa	shingt Under 24 Hrs. lours Min.	8. Date of Bil (Month, Da	Pr	ince (	Georges thplace (State or Foreign ountry) ryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Insportant: If Item 271e marked other then "naturely or Items 23a or 28a-f show any Injury or other traumatic event, the Madical Examinar must be notified at once.	To Be Completed by Funeral Direc	Usual Residence of Decedent  10a. State  10b. County  Maryland Char  10e. Street and Number  3704 Fleet Co  11. Marital Status  1 Never Married 2 Marne  3 Widowed 4 Divorced  (Specify only highest  Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, L.  Robert  19a. Informant's Name/Relationsh  Richard Savoy  20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other (Sp  21. Signature of Fursical Privice Le	Durt  12. Was Dece Armed For 1   Yes If Yes, Giv Year or Day  s Education grade completed)  College (1  ast)  Husban  3   Removal from Secity)	dent Ever in U.sces? 2 No entes:  4 or 5+)  Th	16a. Dece (Give life.) Home 10mps ( 19b. Mailir 3704 lace of Dispo emetery, cref	Head  10f. Zip of 2  Was Decede If Yes, specific Yes, spec	Occupation  No. S  Occupation  R  R  (Street and t Ct e of her place)  Chur	Mother's Nam OSIE Number or Rur	ecify Yes or No Rican, etc.)  ing  e (First, Middle al Route Numb an Hea Date 8/08	10g. Citiz  US  16b. Kin  Do  Maiden S  per, City or  ad I  20c. Loc	ten of What C SA  4. Race - Am Black, Wh Specify Ame ad of Busines: Omest: Surname) P: Town, State, Maryl: cation - City o	erican Indian, ite, etc. ericanIndi s/Industry ic roctor Zip Code) and 20640 r Town, State Maryland
Physician /Medical Examiner	icai Examiner	23a. Part1. Enter the disease, or a shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, I amy learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Hy Due to (  b. Due to (  C. Due to (	POXIC or as a conseque CIF or as a conseque Or or as a conseque	Ence of):	ter the mode	of dying, s	uch as cardiac			,Mary	Approximate Interval Between Onset and Death
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		irth 2 □ Fetal ant at time of de	death 3[	∃Ectopic pre □ Other (spe				2	3d. Date of d	elivery Day Year
V requires man been signed by should be detac	þ	Part II. Other significant condition	ns contributing to de	ath but not resu	ulting in the u	inderlying ca	use given li	n Part I.	1 🗆	Yes 2	]No 3□1	to the cause of death?  Probably 4 Unknown
ten: Ine tav rtificete has stor, page 2	3e Completed	25. Was case referred to medical					26	S. Place of Dea	perf 1 ☐ Yes	opsy formed? 2 No	prior to death?	autopsy findings available completion of cause of s 2 No
eath. or: After this ce he funeral direc	Certification; To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investig	28a. Date of (Mont)	of Injury h, Day Year)	ER/Outpatier 28b. Time o Injury	M 28	3c. Injury at Work? 1 ☐ Yes	4 ☐ Nursing Ho	ome 5 ☐ Res 28d. Describe			ecify)
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		3 Suicide 6 Could n 4 Homicide determi	physician: To the	of Injury - At ho ng, etc. (Specify best of my know	/) wledge, deat	h occurred a	at the time.	date and place,	City or To	own, State)	and manner	Rural Route Number, as stated.
To the Hi within 24 To the Fu completely	Medical	one)	and manr	asis of examinat ner stated.	tion and/or in	ivestigation,	in my opini	on, death occur	red at the time	, date and	place, and di	nth, Day, Year)
B/2	ate	30. Name and address of person with AMID MA  31. Date filed (Month, Day, Year)	who completed caus JD1 MD	e of death (Item at i	ture	Print) h	insto	n Hosp	oital			
Registi		FEB 0	5 2008 🥻	Calva .	D. B.	perel	).					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] [ ] [ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 05 2008 **Physician** Sallie Jane Smith 2:00 p 02 /Medical 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) 4c. County of Death Examiner Montgomery Sligo Creek Nursing Home Takoma Park
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/21/1910 Birthplace (State or Foreign
Country) 7. Age (In vrs. last birthday) **Funeral** 5. Social Security Number 1 □ M 2 🖰 F Days Hours South Carolina Months 97 247-40-9772 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County r than "natural", or items 23a or 28e-f ehow the Medical Examination until the notified at 1 TaYes 2 □ No Director DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20018 3501 South Dakota Avenue, N.E. USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: þ lf Yes, Give Year or Dates: 3 Widowed 4 □ Divorced Black. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry US Postal Service Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Environmental Specialist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pickens Pyles Climmie Elmore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a:: If item 27 ls 3501 South Dakota Ave., NE, Washington DC 20018 Lillie Irby / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any old Lincoln Cemetery 02/11/2008 Brentwood, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ft. Lincoln Funeral Home 21. Signature of Funeral Service Josephsee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. unew B401 Bladensburg Rd., Brentwood, MD 20722 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** mal /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed ician and burial-trans Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🖺 No 4 Pregnant at time of death 5 Other (specify) the Records, P.O. 9 Unknown 9 Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 7 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 20 of Vital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4X Nursing Home 5 TResidence 6 Other (Specify) 1 ☐ Yes 2 ▼No 2 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Deat 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident **Division** 5 Pending investigation death. 1 Yes 2 No Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 M Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 Momicide Hospitel within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier February 6, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3415 Hamw ton 87

DHMH 17 Rev 1/2001

State

Registrar

FEB 0 7 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day T. SMITH FRANCINE FEBRUARY 11:49 /Medical 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE HOSPITAL GERMANTOWN MONTGOMERY 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2√F Months Days Hours Min. 229-82-3520 50 Director MAY 14 1957 VIRGINIA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10b. County 10d. Inside City Limits urai", or items 23a or 28a-f sh I Examiner must be notified 1 Yes 2 No Directo MONTGOMERY GERMANTOWN 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 11828 ETON MANOR DRIVE # 201 20876 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced m 27 is marked other than "natu her traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 10th College (1-4or 5+) STORE MANAGER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be E. JACKSON ALVTN. W. COLEMAN OLIVIA ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MANOR DRIVE # 201 GERMANTOWN, MD 20876 JOSEPH SMITH/HUSBAND 11828 ETON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐Removal from State 2/12/2008 LANDOVER, MARYLAND HARMONY CEMETERY 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Myocard /Medical Due to (or as a consequence of) **Examiner** Due to (or as a consequence of): Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician I for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 225 No Month Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 | Yes 2 | No 3 | Probably 4 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy perform Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 🔲 Inpatient 2ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the l 29c. License number 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) 00065785 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alex ms 9901 No 31. Date filed (Month, Day, CFR 0 7 2008 32. Registrar's S'gnatur Year) State FEB 0 7 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 02 **Physician** 03 20ď8 8:33 Mary E Skinner /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4301 Morningwood Drive 01ney Montgomery Age (In yrs. last birthday 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
11-14-1918 Birthplace (State or Foreign Country) **Funeral** Days Min. Hours 1 □ M 2 🗓 F USA 213-42-8277 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Montgomery MD 01ney Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4301 Morningwood Drive 20833 USA Completed by Funeral 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White 3 Widowed 4 □ Divorced Year or Dates "natural", the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own home 12 Homemaker ages 1 and 2 should be filed ent of Health and Mental Hygis tt: If item 27 is marked other y or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samue1 Steiner Edna Virginia Weems Pages 1 and 2 should 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Whitlock/ son 22018 New Hampshire Ave Brookeville MD 20833 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 02/07/08 Brentwood MD 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee 3401 Bladensburg Rd Brentwood MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) four years **Physician** CORONARY ARTERY DISEASE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) physician Physician/Medical as IF FEMALE nse 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month for in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes → No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 28 No certificate ! 1∏ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 No funeral director 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 3□ DOA 1 Inpatient 2 ☐ ER/Outpatient ٩ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation Injury Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, Hospital or Attending in 24 hours after where the Euneral Director: After the Funeral Director: After the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral fun

within 24 Registrar

DEMNIS HAUNDN MO 2901 DLNE. SANDY SPRING ROAD; 32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 0 7 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Medical

State

(Check only

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

MARYLAND 20832

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			, 101	partment of Health and Menta	al Hygiene 008 04927								
			Registrar  1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg. No. 2 3. Time of Death								
	Physici /Medio		Hampton Herbert Shreev	es Jr. Fe	b Pay 2000 6 AH								
	Examir	ier	5501 Hagruder Ave	4b. City, Town, or Location of Death Suitland	Prince Georgs								
	Funeral Director		5. Social Security Number  6. Sex 7. Age (In yrs. last birthday)  7. The security Number of the security Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Num	Months Days Hours Min. (Mo	le of Birth (State or Breign Country)  1948  9 Birthpiace (State or Breign Country)  Washington, D.C.								
	ryland how at		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location	10d. inside City Limits								
	the Ma	Director	Maryland Prince George's Suitland 10e. Street and Number	10f. Zip Code	★\ Yes 2 \ No								
	be filed within 72 hours after death with the Maryland Hygiene.  ad other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at			20746	United States								
396		by Funeral	11. Marital Status  1 □ Never Married 2 □ Marnied  1 □ Never Married 2 □ Marnied  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican,     □ Yes	es or No- 14. Race - American Indian,								
21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	cedent's Usual Occupation ive kind of work done during most of working e. DO NOT use retired)	16b. Kind of Business/Industry								
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and	ould be fil Mental H arked otl atlc even	Be		18. Mother's Name (First,	Middle, Maiden Surname)								
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Baltimore,	0 0		20a Method of Disposition 20b. Place of Dis	sposition (Name of Date crematory or other place)	20c. Location - City or Town, State								
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Bal	permit. Pag Department Important: I any Injury o once,		21. Signature of Funeral Service Leensee	22. Name and Address of Facility Pope F 5538 Marlboro Pike For	uneral Homes, P.A. estville, Maryland 20747								
ı			23a. Part1. Enter the disease, of complications that caused the death. Do not shock, or heart failure. List of ly one cause on each line.	enter the mode of dying, such as cardiac or respi	ratory arrest, Approximate Interval Between Onset and Death								
	Physician /Medical		disease or condition death)  a. Neta Static Usig Cancer  (a) 10 et a Static Usig Cancer  (a) 11 et a Static Usig Cancer  (a) 12 et a Static Usig Cancer  (a) 12 et a Static Usig Cancer  (a) 12 et a Static Usig Cancer  (b) 12 et a Static Usig Cancer  (c) 13 et a Static Usig Cancer  (c) 14 et a Static Usig Cancer  (c) 15 et a Static Usig Cancer  (c) 16 et a Static Usig Cancer  (c) 16 et a Static Usig Cancer  (c) 16 et a Static Usig Cancer  (c) 17 et a Static Usig Cancer  (c) 18 et a Static Usig Cancer  (c) 1										
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.O. Box	that the death certific ted by the attending p detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery  Month Day Year								
Δ.	8 50	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	3e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown								
Records,	e law requir has been si le 2 should b	Completed		24	4a. Was an autopsy findings available prior to completion of cause of								
E E				1[	performed? death? ☐ Yes 2☑ No 1 ☐ Yes 2 ☐ No								
Vital	Physician: The this certificate al director, pag	Be		26. Place of Death (Chec									
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ion	Attending F death. ctor: After y the funer	ation	1 Matural 5 □ Pending (Month, Day Year) Injui 2 □ Accident investigation	ry Work? M 1 ☐ Yes 2 ☐ No									
Division	or A	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)		tion (Street and Number or Rural Route Number, or Town, State)								
	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	Medical C											
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)								
			(Soon) Jaleut	10 22075 Hi	February 04, 2008								
R	(9)		30 Name and address of person who completed cause of death (Item 23a) (Tyl Shakuntala Malik	3800 Rosezvi	oir Rd DC								
	Sta Regist	ate rar	A 7 7888	,									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2/2/2008 **Physician** 5:12 am Benjamin Sanders /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1⊠M 2□F Director 28 219-02-4763 12/27/1979 Washington Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at MD Prince George's 1 Yes 2 □ No Director Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4426 23rd Parkway 20748 Funeral USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. id 2 should be filed within 72 hours after tth and Mental Hygiene. 27 is m: rked other than "natural", or ite traum: 1c event, the Medical Examine. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 2 3 Widowed 4 Divorced African

16b. Kind of Business/Industry American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) Unemployed None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alfred Sanders Cherlyn Roseby ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is rn any Injury or other traum once. 4426 23rd Parkway Temple Hills MD 20748 ce of Disposition (Name of Date Date 20c. Location City or Town, State Cherlyn Sanders/mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/11/2008 Clinton, MD Resurrection 22. Name and Address of Facility 21. Signature of Funeral Service License J.B. Jenkins Funeral Home 7474 Landover Rd, Landover, MD 20785 Tail. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician P51 disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. End underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2**X** No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 No 2XER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? al or Attending P safter death. I Director: After i d in by the funera 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 2 ☐ Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

Un

Eric McDonald md 7503 SURAALLS RD Clinton, MD 32. Registrar's Signat

FEB 0 6 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DO064055

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Shirley Mae Shawen  $P^{M}$ February 2008 5:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. cial Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 218-34-1263 1 M 250 Months Days Hours Min. 69 Maryland Director 1938 Usual Residence of Decedent 10a. State 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "naturai", or items 23a or Medical Examiner must be r 1031 Skidmore Road 21409 U.S.A. Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 72 hours after 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White ş 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 Health and Mental Hygiene. em 27 is marked other than "nather traumatic event, the Media Elementary/Secondary (0-12) College (1-4or 5+) Nurse Nursing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Gary Shawen Myrtle E. Wilburn 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at
Important: If Item 27 is
any injury or other trau
once. Margaret Ward/sister 1598 Millersville Road Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐Removal from State St. Margaret's Cem. 2/6/2008 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home todo 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction **Physician** 4 days /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9□Unknown à s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed Peripheral Vascular Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy perform 1 Yes 2€No director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 100 Inpatient this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of lospital or Attending P I hours after death. uneral Director: After t After t 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 ☐ Homicide filled in thin 24 hours at the Funeral E Hospital 29a. Certifier Medical \*\*EXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated.

31. Date filed (Month, Day, Year) FEB 0 4 2008 Registrar

29b. Signature and title of certifier

Marco A. Mejia, MD

2002 Medical Parkway, Suite 310 Annapolis, Maryland 21401 gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

D0046303

29d. Date signed (Month, Day, Year)

February 2, 2008

		-	For State Registrar		State of	f Marylar			nt of He te of D		ınd Mei		iene ,	2008	04	930	
	Physicia	an	Decedent's Name (First,						-			Date of Deat Month	Day	Year	3. Time o		
	/Medic	al		Marshal					-			anuary	31	2008		p. M	
	Examin	er	4a. Facility Name (If not ins 3 Shady		treet and nun	nber)			, Town, or L ambric		t Death		4c. C	ounty of Deat	n ester		
-	Funeral		Social Security Number			7. Age (In yrs.	last birthday)	If Unde	er 1 Year	If Under 2		Date of Birth	9. Birthplace (State or Foreign				
	Director		213-24-4597	, 1□	M 2 <b>X</b> F	79	Yrs.	Months	Days	Hours	Min.	(Month, Day, ct. 29	, 19:	28 Ma	untry) ryland		
1	pu >		Usual Residence of Deced	lent Counfy		10c Cir	ty, Town or Lo	cation				•			10d. Inside C	ity Limite	
9	Maryland -f show lied at	ō		Dorches	ster	100. 01	y, Town of Lo	Canon	Cambr	-idae						2 No	
2	28a-i	Director	10e. Street and Number	DOLCTICE				10f. Z	ip Code			1	0g. Citize	en of What Co	untry?		
20	n with		3 Shady	Drive				21613						USA			
B	ems 2	Funeral	11. Marital Status	1	2. Was Dece Armed Fo	edent Ever in U	.S. 13.	Was Dec	edent of His	panic Orig	gin? (Specif	y Yes or No- can, etc.)	14	4. Race - Ame Black, Whit			
98	or it		1 Never Married 2		1 ☐ Yes If Yes, Giv	2 No ve			2 <b>X</b> No	Specify:	,	,			hite		
21215-0036	72 hours after death with the 'natural', or items 23a or 28a dical Examiner must be notif	ed by	3 ☐ Widowed 4 ☐ Di	ecedent's Educ	ates:	16a Dece	dent's Us	ual Occupat	tion		16b. Kind of Business/Industry						
15	in 72 n "na Medic	plet	(Specify only highest grade completed)				(Give	kind of w	ork done du use retired)	uring most	t of working	T	100.100	a or paomesa,	industry		
212	d within giene. er than " the Mec	Completed	Elementary/Secondary (	(0-12)	College (1	1-401 5+)		asser	mbler					electro	nics		
멀	be filed tal Hygie d other svent, the	Be	17. Father's Name (First, I						]			First, Middle, I		Surname)			
yla	2 should be f and Mental H Is marked oi aumatic eve	ပု	Lynn B. M				T					hillips					
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hyglene is the feet at 18 marked other than "natural" or items 23a or 28a-f show then 17 is marked other than "natural" or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Re Kenneth E		•	nusband						_		Town, State, I 1613	(ip Code)		
ď.	ges 1 and 2 t of Health If Item 27 I or other tra		20a. Method of Disposition		1 1	20b.	Place of Dispo	sition (N	ame of	1	Date	dge, MI ∍		ation - City or	Town, State		
П П	Pages ent of nt: If I		1 ☐ Burial 2 🛣 Cren 4 ☐ Donation 5 ☐ C		emoval from	State	cemetery, cre. Lisbur	,	•	· i	2/1/0	08	Sali	isbury,	MD		
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral S		е	150			and Address	-				l Home			
<u> </u>	permit Depar Impor any in		Jh WI	lever				700 I	Locust	st.		oridge,		21613			
			23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine.								Approxima Interval Be	etween					
	Physician		Immediate Cause (Final disease or condition resulting in death)  Onset and Death  Onset and Death										Deau				
	/Medical Examiner		Due to (or as a consequence of):														
	pre .	e.	Sequentially list conditions, if any, isaling to infinediate but to (or ac a concequence of)														
	ate be executed hysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>1</b> .													
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Вох	atten for us	cian	23b. Was decedent pregr in the past 12 month	iatit	1 ☐Live b	oirth 2 ☐ Fet	al death 3[	∃Ectopic ∃Other (	pregnancy specify)				2	3d. Date of de Month	Day	Year	
P.O.	the d	nysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□Unkn			,	, , , , , , , , , , , , , , , , , , , ,								
	res that the de signed by the a be detached f	by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause							n in Part I		23e. Did to	bacco us	e contribute t	the cause of	death?	
ord	w require been sig should b											1 🗆 Y	es 2. □ Ho 3 □ Probably 4 □ Unknown				
S	has be	plet										24a. Was a	SV	24b. Were a	utopsy finding	s available cause of	
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Zita	ician certifi ector	Be	25. Was case referred to examiner?		lospital:				Othe			Check only or					
ō	ding Physician: The In. After this certificate ha funeral director, page	5	1 Yes 2 No	•	28a. Date	Inpatient 2 of Injury	ER/Outpatie		JUA	4 ∐ Nu		d. Describe h		Other (Spe	cify)		
on	th. th: tatee:	ţ		Pending investigation	(Mon	nth, Day Year)	Injury	М	28c. Injury Work 1 ☐ Y	? ′es 2 🗌							
<u> S</u>	or Attending after death.  Director: After in by the fune	iţica	a Societies 6 Could not be							28	28f. Location (Street and Number or Rural Route Number,						
Ö	tal or rs afte al Dir led in	Certification:	4 Homicide building, etc. (Specify)  City or Town, State)														
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		(Check only 2 N	ertifying Phys ledical Exami	ner: On the b	asis of examin										e(s)	
	To the within 2 To the complet	Medical	one) and manner stated.  29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)														
	vith von		Rellon min						D0057040 0					12/21/21/2MDP			
	0		30. Name and address of	person who co	mpleted caus	se of death (Ite	m 23a) (Type,							-11-	_000		
			BRENDON 1	PALTO	10:	5 Ac	Nora	St	_ 0	ant	rido	je, Mi	$\mathcal{L}$	21613			
	Sta Registr		31. Date filed (Month, Day	EB 0 4		Regis Rr's Sign	ature	A	Ry								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Carole 0. 8:38 PM Stephens January 30 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9. Birthplace (State or Foreign Suburban Be The sola Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Nov 2, **Funeral** 1 □ M 2 1 F 578-64-2805 61 1946 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2X No Director MD Montgomery Bethesda 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Item 27 Ia marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a 10638 Weymouth Street #101 20814 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ୦୧ କଦ୍ୟର . Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White Completed by 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Financial Advisor Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (unk) 01ive Genevieve Palumbo 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amanda Ruthann Baylor/daughter 36 Vienna Court Frederick, MD 21702 300 more, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Chesapeake Crematory 02/02/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Ma MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a consequence of): bacterial month disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): abcess Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner bacterial endo cardidis that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the as attending | 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? diabetes mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Cinknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 2 No Hospital or Attending Physician: 1
 Hours after death.
 Funeral Director: After this certifical 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2₩ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 SNatural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0065491 30, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4)00 8600 Old Georgebour Rl., Bethesda, MD 32. Aggistrar's Signature

Alexen B. Aggist Schwartz Daniel 31. Date filed (Month, Day, Year)
FEB 0 5

DHMH 17 Rev 1/2001

State

Registrar

arole

2008

08-00781 John Sullivan Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

John Sullivan	1-	For State	State of Maryland /	pepart / Certit	ment of ficate of	neaim ai Death	iu ivierita	ai i iygicii	Reg. N	ło.	200	18 049		
Physiciar		egistrar . Decedent's Name (First, Mic	Idle,Last)					2. Date Mon	of Death th Da uary 28, 2		ear	3. Time of Death 1740 hrs		
Medical Examine	er	John J. Sull a. Facility Name (if not institu	ivan, III			b. City, Town, o	or Location of		uary 28, 2	4c. Count	y of Death			
	4	a. Facility Name (if not institu Atlantic General Hos				Berlin			Worcester					
Funeral	5	. Social Security Number		e (In yrs. last	birthday)	If Under 1 Ye	ear If Under	Min.	ite of Birth(N		Foreign			
Director		213-56-9035	16 W 2	13	Yrs.			9	/8/196	54	Cour	ntry) GA		
any	-	Jsual Residence of Decedent  0a. State 10b. Coun		10c. City, T	own or Location	on						10d. Inside City Limits  1 Yes 2 No		
ind show a	اة	MD Worcester Ocean Pines 10g. Citizen of V												
Maryla r 28a-f	iec	Ioe. Street and Number				10f. Zip Code			109.		ISA	,		
ath with the Mar items 23s or 28s	Funeral Director	35 Falcon Br	idge Rd.  12. Was Deceden	t Ever in U.S	. 13. Wa	s Decedent of	Hispanic Orig	in? ( Specify Y	es or No-	14. R		an Indian, Black,		
Jeath w	nue	1 Never Married 2	Married Armed Forces'  1 Yes 2  Divorced If Yes, Give Year	? ! X No		es, specify Cut		Puerto Rican,	eic.)		fy: Whi	+0		
s after cral", o		3 Widowed 4 15. Decedent's Education (S	16a Deceden	Yes 2 X	kind of work do	one 1		f Business/Ir						
2 hour	eted	Elementary/Secondary (0-			during m	ost of working	life. DO NOT	use retired)						
5-0036 Iled within 77 Hygiene. d other than	ompleted	11			Home	Build	er 18 Mother	's Name (First,				<u>onstructio</u>		
15-0 filed v al Hygi ed oth	CO	17. Father's Name (First, Mid John J. Sul	ivan ln Betty R						Rehn					
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Ex miner must be notified at once.	ToB	19a. Informant's Name/Relati	ionship (Type, Print)			g Address (S								
MD and 2 sh allth and 27 is raumal	- 1	Betty Sulli 20a. Method of Disposition	van / mother	20b. P	lace of Dispo	alcon B	rage cemetery,	Date	ean P	20c. Locat	ion - City or	Town, State		
Ore, ges 1 a t of He I fite		1 X Burial 2 Crema	ation 3 Removal from S		rematory or o		ines	2/2/20	308	0cea	n Pine	es, MD		
Iltim nit. Pa artmen sortant	}	21/ Sponation 5 Other Specify.  21/ Sponation 6 Funeral Service Licensee / 22. Name and Address of Facility								he Burbage Funeral Home				
		HVM 71/1	e, or complications that cause		Do not ontor	108 Wil	liam S	t., Ber	rlin,	MD 2 st, shock, o	1811 or heart	Approximate Interv		
Physician ledical		failure. List only one ca	ause on each line.					•	•			Between Onset an Death		
aminer		Immediate Cause (Final disc or condition resulting in dea				culai di	<u> </u>							
	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cor	nsequence of	f):									
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b. Bc the dea	Phys	Cocaine use							23e. Did tobacco use contribute to the cause of de					
tal Records, P.O. B. cian: The law requires that the de certificate has been signed by the ector, page 2 should be detached it	d b											autopsy findings availa		
Vital Records, hysician: The law requir this certificate has been s al director, page 2 should 1	Completed								autop		prior to death?	completion of cause		
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Vital F ysician: this certifi director,	å	25. Was case referred to mexaminer?	Hospital:	natient 2	ER/Outpatie		Other:		ing Home 5 Residence 6 Other:					
In of Village Physic After this funeral dir	2	1 ✓ Yes 2 N 27. Manner of Death	28a. Date of		28b. Time	of Injury 28	c. Injury at Wo		d. Describe	how injury	occurred			
ISION of death.	atior	1 X Natural 5	Pending		<u> </u>	ļ,	1 Yes 2		f Location (	Street and	Number or	Rural Route Number,		
Division Division ours after death. eral Director: Affled in by the fi	Certification:	3 Suicide 6	Could not be determined (Specify)	of Injury - At	nome, tarm, s	treet, factory, c	mice building.	, etc.	or Town,					
12 of 15 of				of my knowle	dge, death or	curred at the ti	me, date and	place, and du	e to the cau	se(s) and	manner as s	tated.		
To the Hos within 24 h	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.								ad at the time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)				
	Ž	29b. Signature and title of certifier  O.C.M.E.  O.C.M.E.							nuary 29, 2008					
			person who completed cause	of death (Ite	em 23a)	L_								
		Ling Li, MD As	ssistant Medical Exam	iner 11	1 Penn St	reet, Baltim	ore, MD 2	21201						
Regi	Stat		A A A A A A A A A A A A A A A A A A A	gistrar's Signa	ature	E .								
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State of Maryland / Department of Health and Mental Hygiene

2008 04933

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		- For State Registrar	A statut a hand		Certi	ilicate of	Deain		2. 🗆	Reg. Note of Death	NO	3. Time of Death
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		Saint Agnes Hos		(COC and name -	,		Baltimo					
·		Social Security Number		7. Ac	ge (In yrs. las	t birthday)	If Under 1	Year If Unde	r 24Hrs. 8.	Date of Birth(N	MM/DD/YYYY) 9. E	Birthplace (State or eign
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Director		216-80-5637		4 2 F		115			1_1			
<u>&gt;</u>		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location										10d. Inside City Limits
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with the Maryla ns 23a or 28a-f be notified at or	Director	10e. Street and Number					2122	00		T.	JSA	
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t be r	Funeral	11. Marital Status  1 X Never Married		Armed Forces	3?	If Y	es, specify	Cuban, Mexican	, Puerto Ric	an, etc.)	White, etc	i.
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J36 thin 72 hours af ne. than "natural tedic I Examin	ted	Elementary/Secondary		College (1-4 o		during m	nost of worki	ng life. DO NOT	use retired	)		
So in 72 than than	ble	10	, (,	- 0 ,		N€	ever W					
Z13-UUSD be filed within 7 ntal Hygiene. rked other than ent, the Medic	Completed	17. Father's Name (First	. Middle, Last)					18.Mothe	r's Name (F	irst, Middle, Ma	iden Surname)	
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ZIZ Duld be Ment mark	To B	19a. Informant's Name/F									er, City or Town, S	
MOICE, MID Z 1 Z 1 3-0050 Pages 1 and 2 should be filed within 72 hours after near of Health and Mental Hygiene. Tiftem 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	-	Rev. Tracy	A. Star	ley / Br	other					berdeer.	, MD 210 20c. Location - Cit	OL State
and and lealth lealth ltem	-	20a Method of Dispositi	ion			Place of Dispo crematory or o	sition (Name	e of cemetery,	"	Date	20c. Location - Cit	y or Town, State
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Baltimore, permit. Pages 1 ar Department of He Important: If ite		1///	VUA 11	hla		11.	217 Cc	Funera	7 Dd	Ahingo	on MII 2	1009
	-	23a, Part I. Emer the dis	sease, or comp	i at ons that caus	ed the death	. Do not enter	the mode of	f dying, such as	cardiac or r	espiratory arres	st, shock, or heart	Approximate Interva Between Onset and
Physiciar ledica		failure. List only or	ne cause on ea	chline. Chest an								Death
amine		Immediate Cause (Fina or condition resulting in	l disease a. death)	Due to (or as a co								
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	i	cause. Enter Underlyin (Disease or injury that i	initiated	Due to (or as a co	ncoguence (	υf)·						
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O, e be ex ysician burial	adical	X UNPENDED		#1 / 14 / /	7,28a-f. come of pre	perME,	g877_3/	12/08 TT			23d. Date of de	elivery
ox 6876(eath certificate attending phy	2		gnant in the	1 Live birth			Fetal death	3 Ecto	pic pregnan	псу	Month	Day Year
Box 6876 e death certificate the attending phy	or use as me	past 12 months?			t at time of d	eath 5	Other (Spec	cify)				
30) death	101.0	1 Yes 2 No		9OIRIOW					D 11	220 Did to	bacco use contribu	ute to the cause of death?
at the	Day of		int conditions	contributing to d	eath but not	resulting in th	e underlying	cause given in	Part I.			Probably 4 V Unknown
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ds require	should									autop	sy pri	or to completion of cause o
law las las	s 7 a									1 ✓ Yes		ath? ✓ Yes 2 No
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of Vital Records, P.O. ing Physician: The law requires that the Physician: The law requires that the After this certificate has been signed by the After this certificate.	rector	examiner?		Hospital: 1 Inc	patient 2	✓ ER/Outpati	ent 3	Other Other	Nursing	g Home 5	Residence 6	Other:
	[ 등	1 Yes 2 27. Manner of Death	No	28a. Date of		28b. Time		28c. Injury at W	ork?	28d. Describe	how injury occurre	d - fight and
n of ding P	true	Natural	Pending	(Month, I	Day,Year)	6.20	om	1 Yes 2	χNο	subject	involved i	n a fight and
Sior Vittend death.	oy the	2 Accident	Investiga	tion Place	2, 2008	6:20 home, farm, s	street, factor	y, office building	, etc.	oof Leading (	Ctroot and Numbe	r or Rural Route Number, C
Division tal or Attendirs after death.	u l	1 Natural 2 Accident 3 Suicide 4 X Homicide	Could no determine	t be	hospita	-				55 Wade	Ave. Caton	Grove Hospital sville, MD
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physon to the Funeral Director: After this certificate has been signed by the attending physon of the control of t							courred at th	e time, date and	d place, and	due to the cau	se(s) and manner	as stated.
ne Ho n 24 l	pletel	(Check only one) 2 M	ertifying Physic edical Examina	er:On the basis of	examination	and/or invest	tigation, in m	y opinion, death	occurred a	t the time, date	and place, and du	ue to the cause(s)
To the within To the	com	(Check only one) 2 M		and manner sta	ated.			c. License num			29d. Date signe	d (Month, Day, Year)
		Z 290. Signature and the						O.C.M.E.			February 13	3, 2008
		Cerce				00-)						
		30. Name and addres		completed cause ant Medical E	e of death (It	em 23a) 111 Pon	n Street	Baltimore, N	MD 2120	1		
		Ana Rubio Mi					0					
	Sto	te 31. Date filed (Month,	Day, Year)	32 Reg	gistrar's Sign	aure	2.16 2					

Registrar

OCME

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** HAROLD WESLEY SHOEMAKER, JR. JANUARY 28, 2008 1310 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND ALLEGANY WMHS-Memorial Campus If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 ₹M 2 □ F Days Months Hours 42 Director 219-76-3427 Maryland 04/16/1965 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show be notified at 10a State 10b. County 1 ☐ Yes 2 X No LaVale Director MD Allegany 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 75 National Highway 21502 "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21☑ No Specify ð 3 ☐ Widowed 4 🎇 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any Injury or other traumatic event, the Mediconce. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Laborer Municipality 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mallow Harold Wesley Shoemaker, Sr. Dianne Gertrude ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) National Highway, LaVale, MDDianne G. Shoemaker / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Memorial Park 01/31/2008 Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service Licensi 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 5 YEARS CIRRHOSIS OF LIVER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate clause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. physician Physician/Medical the IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.0. s been signed by the should be detached 9∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed?

1 Yes 2 No certificate Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident al or Attend s after death the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours af To the Funeral D 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JANUARY 29, 2008 D36766 63 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 924 SETON DRIVE, CUMBERLAND, MD 21502 VIK POONAI, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			1 = For State Registrar	State of Maryl				Mental Hygie	ene 2 nn 8	04.936
			Registrar  1. Decedent's Name (First, Middle, La	- 41		ertificate of	Death		. No.	7 0 9 7 0 0
	Physici	an	Jean	•	C = l			2. Date of Death Month	Day Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, giv		Schwar		or Location of Death	Januari	4c. County of Dea	2 11,
	Examin	er	Lions Ctr for Rel		Care		perland	4	,	
_	Funeral		5. Social Security Number 6. S		yrs. last birtho	ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Alle	thplace (State or Foreign
	Director		215-36-9574	□M 2XIF 94	Yn	Months Days	Hours Min.	(Month, Day, Y	ear) Co	ountry) 'yland
	Pu ,		Usual Residence of Decedent					110725715	1101	
	arylar show d at	_	10a. State 10b. County  MD Alleg		. City, Town o					10d. Inside City Limits
	he M. 8a-f otifie	ecto		any		Cumberland				1 M Yes 2 No
	with t	ä	10e. Street and Number 305 Mt. View	Drive		10f. Zip Code	21502	109	i. Citizen of What Co USA	ountry?
	leath	Funeral Director	11. Marital Status	12. Was Decedent Ever i	in II.S			pecify Ves or No-	14. Race - Ame	erican Indian
^	r Iten	臣	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No	0.0.	<ol> <li>Was Decedent of F If Yes, specify Cub</li> </ol>	an, Mexican, Puerto	Rican, etc.)	Black, Whit	
2	urs a al", o Exam	b	3 M Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify:	White
ה ה	72 ho natur Ilcai	ted	15. Decedent's Ed (Specify only highest gra	lucation	16a. De	ecedent's Usual Occup	pation	16	b. Kind of Business	/Industry
V	ithin he. Mec	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	- 'iii	ive kind of work done te. DO NOT use retire	d)	ung		
V	lygier lygier her th		12		0	wner and O			Retail St	tore
2	be fill ad ott	Be	17. Father's Name (First, Middle, Last,					e (First, Middle, Ma	,	
ž	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	P	Abraham  19a. Informant's Name/Relationship (		sman	ailing Address (Street	Beulah		Groper	
2	id 2 s ith an 27 is r traur		Lee Schwartz / So	**	I .	o5 Mt. Vie				215 Code) 1502
נֿע	s 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Mental Hygiene at the 23 is marked other than "natural", or tiems 23a or 28a-f show then 27 is marked other than "natural", or tiems 25a or 28a-f show other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition		b. Place of Di	sposition (Name of	- i		c. Location - City or	
5	Pages ent of nt: if i		1 M Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		-	crematory or other pla w Cemetery	i i		umberland	
	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra		21. Sunature of Funeral Service Licer		Dabovie					Home, P.A.
Ď	Depar Depar Impo any Ir		Kere L	Udam	5			t, Cumber		21502
ı			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the cone cause on each line.	leath. Do not	enter the mode of dyin	ng, such as cardiac	or respiratory arrest	t,	Approximate Interval Between
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	/Medical		resulting in death)	Due to (or as a con			7			Syline
	Examiner	_	Sequentially list conditions,	b. ———	_					
	pe tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence of):					
9	al-trar	xan	that initiated events resulting in death) Last	c Due to (or as a con	sequence of):					
0000	ificate be executed physician and as the burial-transit	alE	(	a						
0	ifficate g phy as the	edical		d						
5	death certific attending p	M/m	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pre		0.00			23d. Date of de	livery
כ	deat e attr	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown		3 □Ectopic pregnancy 5 □ Other (specify) _	y 		Month	Day Year
	at the	Physician/M	9 □ Unknown							
ñ	The law requires that the death cert tee has been signed by the attending bage 2 should be detached for use a	by	Part II. Other significant conditions	ontributing to death but not	resulting in th	e underlying cause giv	en in Part I.			the cause of death?
5	w requir been si should t	sted						1 Yes	21/No 3 P	robably 4 Unknown
נ	ne law	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
								performe	d? death? No 1 ☐ Yes	2 No
-	nysician: nis certifica director,	Be	25. Was case referred to medical examiner?	Hospital:		tiont all DOA Oth	or 1/	h (Check only one)		
5	Phys ral di	5	1 ☐ Yes 2 No 27. Manner of Peath	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpa 28b. Tim	tient 3 DOA	4 L Nursing Ho	ome 5 Residence 28d. Describe how	ce 6 Other (Spe	cify)
5	ding R	tion	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	r) Inju	y Wor	k? Yes 2 □ No	20d. Describe now	injury occurred	
2	Atter r dea ector by the	ifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - A	t home, farm,			28f. Location (Street	et and Number or Ri	ural Route Number,
5	s afte	Certification:	4   nomicide	building, etc. (Sp	есіту)			City or Town, S	State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,		29a. Certifier 1 Certifying Ph	ysician: To the best of my niner: On the basis of exan	knowledge, d	eath occurred at the ti	me, date and place,	and due to the caus	se(s) and manner as	s stated.
	To the H within 24 To the F complete	ledical	uney	and manner stated.	mination and/o			rred at the time, date	e and place, and due	e to the cause(s)
	with .	Σ	29b. Signature and title of certifier	0/		29c. Licens			Date signed (Mont	
	5					Do	23371		JAN 1 31	1, 2008.
	71 00		30. Name and address of person who	completed cause of death (	. 1	L 0	1		- of im	0,2008. Dal50a
	M/S Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Si		on Uriv	e, Cu	mperi	arul, 111	D 31203
	Registra		JAN 3 1	2008	13.	Bracke				

		•	State Registrar				Ce	ertificate	e of l	Death			Reg. No				
		(5-	1. Decedent's Name (First, Midd	lle, Last)				2. Date of Death Month Day					v Yea		Time of Death		
	Physicia /Medic	_	George		Say	ag					J	anuary				0:50 P	
	Examin	100 15	4a. Facility Name (If not institution	on, give street	and number)			4b. City,	Town, or	r Location o	of Death		40	. County of D	eath		
			Suburban Hosp:	ital				Bethesda Montgomery									
	Funeral		5. Social Security Number	6. Sex 1 M M 2			ast birthday	/) If Under Months	1 Year Days	If Under Hours		<ol><li>Date of B (Month, D</li></ol>			Birthplace Country)	(State or Forei	
	Director		218-13-7007	I KN IVI 2		78	Yrs.					01/01/	1930	Mo	rocco	)	
	pu >		Usual Residence of Decedent  10a. State 10b. Count			10c, Cit	/, Town or I	_ocation					10d. Inside City L				
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	he M 28a-f otifie	ectc	10e. Street and Number	omery		Mon	L gome.	ry Vil		2			10g. Citizen of What Country?				
	with t	<b>Funeral Director</b>			041-								Isra	_			
	s 23	eral	18100 Royal Bo		as Decedent		S 13	208		lispanic Ori	igin? (Spe	cify Yes or N		14. Race - A	merican Ir	dian,	
	item item	Į.	11. Marital Status 1 □ Never Married 2 🔀 Ma	l A	rmed Forces? ☐ Yes 2 X	)		13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						Black, V	hite, etc.		
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Ex miner must be notified at	by F	3 ☐ Widowed 4 ☐ Divorce	l If	Yes, Give ear or Dates:			1 ☐ Yes	2 <b>X</b> No	Specify:				Specify: \[	Thite		
Ş	tura sal E	ed	15. Decede	nt's Education	1	· · · · · · · · · · · · · · · · · · ·	16a. Dec	edent's Usu	al Occup	pation	A = 6 ulcin		16b. F	(ind of Busine	ss/Industr	у	
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212	y with	E	8				Manag	ger					War	ehouse			
P	filed othe	Be C	17. Father's Name (First, Middle	e, Last)						18. Mothe	er's Name	(First, Midd	Middle, Maiden Surname)				
<u>a</u>	ald be fenta rked ric ev	To E	Chaim Sayag							Miri	am B	etash					
ary	shot and N s mai		19a. Informant's Name/Relation	nship (Type. P	rint)		19b. Ma	iling Address	s (Street	and Numb	er or Rura	l Route Num	ber, City	or Town, Sta	e, Zip Cod	20886	
Ž	alth alth 227 le		Odette Sayag -	- Wife			1810	00 Roy	al B	Bonnet				ery Vi			
Je.	of He		20a. Method of Disposition	a □ Bamas	ual from State		Place of Dis cemetery, c	position (Nai re <i>matory</i> or o	me of other pla	ice)	D	ate	20c. L	ocation - City	or Town,	State	
Ĕ	Page Pent of Int: If		1 Burial 2 □Cremation 4 □Donation 5 □Other	(Specify)	vai irom State	Mt.	Leba	non Ce	emet	ery	01/31	/2008	Ade	elphi,	MD		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eximiner must be notified at once.		21. Signature of Funeral Service	e Licensee			T	22. Name a	nd Addre	ess of Facili	ity	1 Diro	ctio	n, Inc le, MD			
m	an De De De De De De De De De De De De De		asstan				]	löÿî k	ockv	ille"	Pike	Roc	kvil	lė, MD	2085	2	
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complicatio	ns that cause	d the deat	h. Do not e	enter the mod	de of dyi	ing, such as	cardiac o	r respiratory	arrest,		Ap	proximate erval Between	
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150 Nox	ath ce tendi		23b. Was decedent pregnant in the past 12 months?	1	f yes, outcom I ∐Live birth	2 Fet	al death	3 ∐Ectopic p	oregnand	су				23d. Date o Month	f delivery Da	/ Year	
571	e dea he at ed fo	Physiclan/	1 Yes 2 No		‡□Pregnant : 9□Unknown	at time of	death	5 ☐ Other (s	pecify) _				-				
P.0	at the	Phy	Part II. Other significant cond	iti one contribu	ting to dooth	hut not ro	sulting in the	underlying	cause di	iven in Part	1	23e Di	d tobacco	use contribu	te to the c	ause of death	
	es th igned be de	Ş	Part II. Other significant colld	ILIONS COMME	ning to death	But not res	sulting in the	e underlying	oause gi	IVOIT IIIT CIT	1.					y 4 ∐Unkno	
orge.	equii	ted															
Georg∈ Vital Reco	law lass be	Completed										24a. W	itopsy	pric	r to compl	findings availa etion of cause	
	The ate h page	Š										1□ Ye	erformed?	lo dea	Yes 2	No	
G€ Vital	sian: ertific ctor,	Be (	25. Was case referred to medi examiner?						10.		e of Deatl	(Check on	ly one)				
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	ng Pl fter tl nera		27. Manner of Death 1 Natural 5 ☐ Pen	l l	8a. Date of In (Month, D	jury Jay Ye <i>ar)</i>	28b. Time Injui		28c. Inju			28d. Describ	e how in	jury occurred			
1 a	endil sath. or: A he fu	ätic	2 ☐ Accident inve					М		Yes 2							
Jayag Division	irect irect	Certification:	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	ermined 2	8e. Place of in building, e	njury - At h etc. <i>(Sp</i> ec	iome, farm, i <i>fy)</i>	street, facto	ry, office	9		28f. Location City or	n (Street Town, Sta	and Number ate)	or Hurai H	oute Number,	
Sa Div	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely illied in by the funeral director, page 2 should be detached													(-)d		al .	
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	7 w ti	Σ	29b. Signature and title of cert	2 2000		10					9			ing 29		08	
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	V		30. Name and address of pers														
	-	_	Dr. Petek Don		119 Ro	ckvil strar's Sigr	le Pi	ke, Ro	ckv	ille,	Mary	land	208	52			
	St Regis	tate trar	31. Date filed (Month, Day, Ye FEB 0	4 2008	A second	AR A	B.	mark	-								
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				For State Registrar		State o	f Maryla		artment of F	Health and N Death		giene Reg. No.	2008	04938
		/siciai		Decedent's Name (Fin  Thomas		,					2. Date of De Month Februa	ath Day	, 2008	3. Time of Death
		ledica amine		4a. Facility Name (If not			mber)		4b. City, Town, o	or Location of Death		1	County of Death	0934 A.
				Harford N	iemori:	al Hospi	tal		Havre	de Grace		F	Harford	
	Fund Direct	_		5. Social Security Number 287–32–52	ir 6.	Sex 1⊠M 2□F		s. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir 3/8/19	th Year)	9. Birth Cou Ohic	place (State or Foreign ntry)
	p ,	200		Usual Residence of Dec	dent County		100.0	ity, Town or L	ti					10d, Inside City Limits
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	A C		<u></u>	607 Rowe	Dr				2100	1			5.A.	nuy?
	death		Funeral Director	11. Marital Status	<i>D</i> <b>.</b>	12. Was Dece	edent Ever in	U.S. 13.		Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No		4. Race - Ameri	can Indian,
2 5	`		≥∣	1 Never Married 3 Widowed 4		Armed Fo 1 X Yes If Yes, Giv Year or D			If Yes, specify Cub 1 ☐ Yes 2 ☑ No		Rican, etc.)		Black, White, Specify:Whit	
26	72 hours	S S	Ed .		Decedent's E			16a. Deci	edent's Usual Occup	pation during most of work	ring.	16b. Kin	d of Business/Ir	dustry
7		WB	Completed	Elementary/Secondary		ra <i>de completed)</i> College (1	-4or 5+)	life.	DO NOT use retire	d)	ing			
3	other then		ទ្ធ	12				Civi	l Service	· · · · · · · · · · · · · · · · · · ·			6. Gover	nment
60	Maryland Z1Z15-0035 d 2 should be filed within 72 hours aft tith and Mantal Hygiane. 27 is marked other then "naturel", or	atic even	lo Be	17. Father's Name (First)  John Sto		t)				18. Mother's Nam			Sumame)	
	and 2 sho	traum		19a. Informant's Name/F			e)		ing Address (Street Rowe Dr.	and Number or Rui Ab	erdeen,			21001
∞	Baltimore, Dermit. Pages 1 a. Department of Hee	ry or oth		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cre 4 ☐ Donation 5 ☐	mation 3		State	cemetery, cre	osition (Name of omatory or other pla uneral Ch	apel 2/18	Date /08		ation - City or T	
0/4	baltimore, permit. Pages 1 an Department of Heel important: If Item 2	eny Inju		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399										
0				23a. Part1. Enter the dis shock, or heart fail	ease, or cor	n ications that	sused the dea	ath. Do not er	Aberdeen . Iter the mode of dyi	Mary I and ng, such as cardiac			,	Approximate Interval Between
•	Physic /Medi Exami	cal		Immediate Cause (Final disease or condition resulting in death)	(	a	10	espir	L.	Fall	ore Pulm	nu 7 (	duese	Onset and Death
7	icate be executed physicien end	me ourial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. QVENDSCLEDE Cander Vancular Cheeke Due to (or as a consequence of):  Due to (or as a consequence of):									•	
5	cords, P.O. box of wrequires that the death certifica been signed by the attending ph	ached for use as it	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregin the past 12 mont 1  Yes 2 No 9 Unknown			irth 2 ☐ Fei ant at time of	tal death 3	□Ectopic pregnanc	у		2:	3d. Date of deliv Month	ery Day Year
-	rds, r quires that n signed t		d by P	Part II. Other significant	conditions	contributing to de	or son sud rese	7/ A ~	underlying cause giv	ven in Part I.				he cause of death?
STOUT,	e law	age 2 short	эшріет									psy ormed?	prior to co death?	opsy findings available impletion of cause of
53	VICAL Thicten: Th	ا ا		25. Was case referred to	medical					26. Place of Deat	1 Yes		1 🗆 Yes	2∐ No
S	OI VIIIA Physicien: this certific	5 6	0 26	examiner? 1 ∑Yes 2 ☐ No		Hospital:	npatient 2[	☐ ER/Outpatia	nt 327 DOA Ott	200		-	☐Other (Speci	(v)
	oding Physics: After this	a Tunera		27. Manner of Death	Pending investigation	28a. Date of	-	28b. Time (	of 28c. Injur		28d. Describe			<b>y</b> /
	DIVISION al or Attending s efter death.	ni ya ni bi	Certification;		Could not determined	259. Place	of Injury - At ng, etc. (Spec	home, farm, s	reet, factory, office		28f. Location (. City or Too		Number or Run	al Route Number,
	To the Hospital or Attending Physician 24 hours efter death.  To the Funerel Director: After the	alletery Tills	Medical	29a. Certifier 1 (Check only one)	Certifying P Wedical Exa	miner: On the ba	best of my kr asis of examin ner stated.	nowledge, dea nation and/or i	th occurred at the transcription, in my o	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) a date and p	and manner as s place, and due t	stated. o the cause(s)
	To the within To the	Comp	ž	29b. Signature and title o	of certifier	My	)		29c. Licens	20215		29d. Date	signed (Month,	Day, Year)
	Bt			30. Name and address of FRMA.		o completed caus			Print) Vmian av	e Warn	ode Sias	w M	0,2010	18
	Do.	State		31. Date filed (Month, Da	y, Year)	2008 32. R	gistrar's Sign	nature	Cartes.					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Vear Grace H. Schaffer .50 AM FEBRUARY 06,20060 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11512ENS URSING Dz GRACE Home Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 02/19/1931 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 1 X F Min 233-44-8800 Virginia. 76 Director Usual Residence of Decedent 10H894%ord 10d. Inside City Limits 18erstand Travre de Glace "natural", or Items 23a or 28a-f show rilcal Examiner must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 909 Eugene Drive 21078 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. 3 Widowed 4 Divorced Year or Dates: Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Şeçondary (0-12) Is marked other than College (1-4or 5+) s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 Is marked other than Clerk Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Rutherford Afton Rutherford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 418 Bayview Drive Havre de Grace, MD 21078 19a. Informant's Name/Relationship (Type. Print) Kimberly Donovan (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Harpord Mem. Gardens 2/9/2008 4 Donation 5 Dother (Specify) Aberdeen. Maryland 22. Name and Address of Facility 21. Signate <sup>22. Name and Address of Facility</sup> Zellman Funeral Home, 123 S. Washington St. Havre de Grace, 23a. Part1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 5 Other (specify) P.O. detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a, Was an has autopsy page certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 2/2 No To the Hosping. Within 24 hours after death.

To the Funeral Director: After this of the Funeral Director After this of the Funeral director. 1 🗌 Yes 1 Inpatient 2 ER/Outpatient Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Injury Natural 5 Pending investigation 1 TYes 2 TNo 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year, Monos 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) FEB 16 32. Begistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician February 09 2008 Smith Dora Virginia /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown Washington Washington County Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🛣 F Director 220-42-5399 92 1915 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Examiner must be notifiled at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Director Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 12906 Fountain Head Rd. 21742 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. IXIYes 2 No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: 3 ☐ Widowed 4 X Divorced White Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ Clyde Bowers Nellie Virginia Semler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Susan C. Banks/Daughter 12906 Fountain Head Rd., Hagerstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages ' Department of I Important: If It any Injury or c 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 2/11/2008 Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel S.Ma 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part1. Enter the disease, or complicatins that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one or use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Attensilensis Physician eans resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ng physician as the burial Physician/Medical attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliven 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 □Ectopic pregnancy jo Month Day Year 4⊡Pregnant at time of death 5 Other (specify) ned by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To this after death.

I Director: After this d in by the funeral d 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of 29c. License number 29d/Date signed (Month, Day, Year)

State Registrar 1.08

31. Date filed (Month, Day, Year)

o completed cause of death (Item 23a) (Type, Print)

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-00999 State of Maryland / Department of Health and Mental Hygiene Brian M. Speckmeier, Jr. Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 0731 hrs February 4, 2008 Medical Examiner Brian A. Speckmeier, Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Glen Burnie Baltimore Washington Medical Center If Under 24Hrs. Date of Birth(MM/DD/YYYY)Birthplace (State or If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 3 Hours Country)Maryland Director n/a 1, 2007 1 X M 2 F Yrs Dec. Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 X No s 23a or 28a-f show e notified at once. Maryland Anne Arundel Glen Burnie Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 415 Baylor Rd. 14, Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status ment of Health and Mental Hygiene.
rtant: If item 27 is marked other than "natural", or items
or other traumatic event, the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Armed Forces? Married Yes White Specify: Yes 2 X No specify. Pages 1 and 2 should be filed within 72 hours after Yes, Give Yes Widowed 4 Divorced þ 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+ Elementary/Secondary (0-12) Baltimore, MD 21215-0036 NA NA NA NA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Latisha Brown Brian A. Speckmeier, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Cheryl Speckmeier (Grandmother) 8515 Baver Dr. T4 Springfield, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 2-8-2008 Waldorf, MD Trinity Mem. Gdns. 4 Donation Other Specify: 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature #Funeral Service MD 20735 6633 Old Alexandria Ferry Rd. Clinton, Approximate Interval complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part L. Enter the Physician Between Onset and st onl /Medical Death Sudden infant death syndrome (SUDI) Immedia Caus I hal disease or condition resulting in death) caminer Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed

perME.g877 3/10/08 TT

23c. If yes, outcome of pregnancy

Pregnant at time of death

Live birth

and manner stated

Registrar's Signatu

De SAR

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

XUNPENDED

past 12 months?

23b. Was decedent pregnant in the

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Ling Li, MD

IF FEMALE

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 burs after clearh. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans
--

1 Yes 2 No 9 Unknown		eath 5 Other (Sp	pecify)		
Part II. Other significant conditions cor	ntributing to death but not r	esulting in the underlyii	ng cause given in Part I.		se contribute to the cause of death?  No 3 Probably 4 Unknown
				24a. Was an autopsy performed? 1 ✓ Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
25. Was case referred to medical examiner?  1 / Yes 2 No	oital: 1	ER/Outpatient 3	26.Place of Death (Check	only one) ing Home 5 Residence	ce 6 Other:
. 27. Manner of Death 1 X Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury	y occurred
2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h (Specify)	nome, farm, street, facto	ory, office building, etc.	28f. Location (Street and or Town, State)	d Number or Rural Route Number, City
29a. Certifier 1 Certifying Physician: (Check only one) 2 Medical Examiner: On	To the best of my knowled the basis of examination a	ige, death occurred at tand/or investigation, in	the time, date and place, an my opinion, death occurred	nd due to the cause(s) and at the time, date and place	manner as stated. e, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

Fetal death

3 Ectopic pregnancy

DHMH 17 Rev 1/2001 **OCMF 2006** 

State

Registra

**ORIGINAL** 

OCME

23d. Date of delivery

Month

Day

29d. Date signed (Month, Day, Year)

February 5, 2008

Year

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 28, Aprox 12:30A 2008 Edward James Tyler JAN. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Caroline Preston 4835 Frazier Neck Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthdav) 5. Social Security Number 6. Sex **Funeral** 1 **X**M 2 □ F 75 239-42-0074 Yrs. North Carolina 1, 1932 Aug. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Preston Caroline 1 ☐ Yes 2 No MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21655 United States 4835 Frazier Neck Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No SpecifAmerican Indian λq 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Drywall Contractor Drywall 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sally Jones Walter Ellis Tyler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 230 Apple Lane, Preston, MD 21655 Robin L. Wooters/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ty Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/01/08 Preston, Maryland Junior Order Cem. 22. Name and Address of Facility Framptom Funeral Home, 1 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licensee Muhael 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sixonites **Physician** Myo Cardial /Medical Due to (or as a consequence of) Zoylars Examiner Coronary acting dis Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequance of) Examine requires that the death certificate be executed burial-trai Due to (or as a consequence of) physician a Box 68760. Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9∐Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 | Yes 2 | No 3 | Probably 4 | Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No nypertension 24a. Was an autopsy performed Yes 2 No certificate has page 2 ling (ancer 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Mallhen Finher 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 1 MATTHEW FISCHER UP 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 1:45\_ 02/04/2008 <u>Jean Elizabeth Townend</u> 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Silver Spring Renaissance Gardens Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Days 87 1 □ M 2 🖬 F 2/01/1921 Washington DC 214-42-6975 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1√□Yes 2□No Silver Spring MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20904 USA 3160 Gracefield 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11 Marital Status Black, White, etc. White 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Federal Government College (1-4or 5+) Elementary/Secondary (0-12) <u>Customer Service Representative</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bessie May Fulk Leland Stutzman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 9204 Weant Dr., Great Falls, VA 22066 Betty Webb / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Ft. Lincoln Cemetery | 02/07/2008 | Brentwood, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee mohia 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 10 Mins Cerebrovascular Infarction Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year 9☐ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 🔲 Yes 2 ☐ No

hysician /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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**Funeral** 

Director

Show r 28a-f shov notified at

ō must be

23a

"natural", or items

Hygiene. other than "natura ent, the Medical E

. Pages 1 and 2 should be file treent of Health and Mental Heant: If item 27 is marked oth lury or other traumatic even

permit. Pages Department of Important: If it any injury or o

death

filed within 72 hours after

Baltimore, Maryland 21215-0036

in by the funeral

Examine Physician/Medical 2 Be Completed Certification: To

Medical

29a. Certifier

29b. Signature and

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uncerfying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Multiple Cerebrovascular Infarctions High Blood Pressure med? 2∐No 1☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion death occurred at the cause(s) and manner as stated.

State

Terthe Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending abused and

Division or Vital Records, P.O. Box 68760

29c. License number D24093

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

02/05/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3110 Gracefield Rd., Silver Spring, MD 20904 Mark Parkhurst, MD,

31. Date filed (Month, Day, Year)

FEB 0 7 2008

Registrar

	•	For State Registrar		Oldio Ol I	viaiyiaii		artment of F rtificate of		Worker 119	Reg. No. 2	008	04941
Dhysisia	_	1. Decedent's Nan	me (First, Middle,	Last)					2. Date of D	- 11111	Year	3. Time of Death
Physicia /Medica	_		Hawthorn						01	30	2008	7:35 a <sub>M</sub>
Examine	er			give street and number		h		r Location of Dea	ith		ty of Death Arunde	.1
Funeral		5. Social Security			α Kena Age (In yrs. I		If Under 1 Year			rth		: L ce (State or Foreign ')
Director		579-14-4		1□M 2 <b>⊠</b> F	9	7 Yrs.	Months Days	Hours Mir	05/05/			ore, MD
and	ŀ	Usual Residence of 10a. State	of Decedent 10b. County		10c. City	, Town or Lo	cation				10d	. Inside City Limits
h the Maryland rr 28a-f show notified at	ō	MD	Prince	Coorgas		Hwat	tsville					1 <b>⊠</b> Yes 2 ☐ No
ith the or 28a	Director	10e. Street and No		Georges		пуас	10f. Zip Code			10g. Citizen of	f What Country	1?
eath with		9227 Rig	gs Road				20	783		Ţ	JSA	
er dea	Funeral	11. Marital Status		12. Was Decede Armed Force	s?	S. 13.	Was Decedent of F If Yes, specify Cub	lispanic Origin? ( an, Mexican, Pue	Specify Yes or Norto Rican, etc.)	o- 14. Ra Bla	ace - American ack, White, etc	
filed within 72 hours after death with the Maryland Hygiene. ther than "natural" or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by F		rried 2 Married 4 Divorced	1 ☐ Yes 2 If Yes, Give Year or Date			1 ☐ Yes 2 🖾 No	Specify:		Speci	<sup>ify:</sup> Whit	Δ.
2 hou	ted	/Cnc	15. Decedent's	Education		16a. Dece	dent's Usual Occup	pation	orkina	16b. Kind of I	Business/Indus	
ithin 7	Completed	Elementary/Sec	condary (0-12)	College (1-4e	or 5+)		kind of work done DO NOT use retire		orking	1	-	s County
Hygier then the then the then the the then the then the then the the the the the the the the the the	် ပ	17. Father's Name		net)		Caf	eteria M		ame (First, Middle		School	.s
d be f ental h ced of	Be C		awthorne	151/					Hatfiel		ime)	
shoul ind Ma ind Ma in marl	욘		Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Street	and Number or F	Rural Route Numi	per, City or Town	n, State, Zip C	ode)
and 2 salth a n 27 is er tra		Ruth Watt	tay/Daugl	nter			Riggs Roa	d Hyatts	sville,	MD 2078	83	
of He if item		20a. Method of Dis		☐Removal from Sta	. 0	emetery, crer	sition (Name of matory or other pla		Date		- City or Towr	•
t. Pag tment tant: I ijury c		4 ☐ Donation	5 Other (Spe	cify)	Ft.		oln Cemet				-	
permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar" or items any injury or other traumatic event, the Medical Examiner mione.		21. Signature of F	uneral Service Li	A I	at Rav	-	2. Name and Addres 401 Blade					
1	7	23a. Part1. En er	the disease, or co	omplications that causely one cause on each	sed the death							pproximate
Physician		Immediate Cause disease or conditi	(Final	or a	i iii.e.	Nove	read	2, 0 A	20te	Len	Ö	nset and Death
/Medical Examiner		resulting in death)		Due to (or	as a consequ	ience of)	0	el A	1			
On	_	Sequentially list of if any, leading to i	onditions,	b	as a consequ	lence of):	nat	) JW	ruff	en	×	·
ured Insit	Examiner	Cause (Disease o	erlying or injury	Due to (or	as a consequ	ience or).			O			
executing and ial-tra	Exal	that initiated event resulting in death)	ts Last	c Due to (or	as a consequ	ence of):						<u>.</u>
eath certificate be executed attending physician and for use as the burial-transit	edical			d								
ertifice ling ph e as th	Med	IF FEMALE:										
The law requires that the death certilate has been signed by the attending bage 2 should be detached for use a	Physician/M	23b. Was deceder in the past 12	2 months?	23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnan	n 2 □ Fetal	death 3□	Ectopic pregnanc	у			ate of delivery flonth Da	ay Year
y the d	JSIC	1□Yes 2 9□Unknow		9□Unknow		alri 5L	Other (specify) _					
w requires that the dibeen signed by the should be detached	by Pr	Part II. Other sign	ificant condition	s contributing to deatl	but not resu	Iting in the u	nderlying cause giv	en in Part I.	23e. Díd	tobacco use cor	ntribute to the	cause of death?
en sig	ed		De	nen	MA				10	Yes 2₺ No	3 ☐ Probab	ly 4 □Unknown
law re as be 2 shr	plet								24a. Was		. Were autops	y findings available
The cate h	Completed								perf 1∐ Yes	ormed? 2KINo	death?	□No
certifi	Re	25. Was case reference examiner?		Hospital:			t 3ELDOA Oth	or.	eath (Check only			
Phys er this eral di	0 :	1 ☐ Yes 2X 27. Manner of Dea		28a. Date of I	njury	ER/Outpatien 28b. Time of	1 JU DOX	4 K Nursing	Home 5 ☐ Res 28d. Describe	idence 6 00 how injury occu		
une Affe	5	1 X Natura! 2 ☐ Accident	5 ☐ Pending investigat		Day Year)	Injury		rƙ?  Yes 2∐No				
er: a	(C)	0 - 0 - 1 - 1 -	6 ☐ Could not	ad   Zee. Place of	injury - At ho etc. (Specify	me, farm, str	eet, factory, office			(Street and Nurr wn, State)	nber or Rural F	Route Number,
r Attend er death irector; /	tifica	3 ☐ Suicide 4 ☐ Homicide	ol ata main.	bulluling,						,,		
oital or Attend urs after death eral Director; ,	Certification:	4 ☐ Homicide	determine				4					
e Hospital or Attend 24 hours after death e Funeral Director; , letely filled in by the f			determine	Physician: To the becaminer: On the basis	of examinat	wledge, death tion and/or in	n occurred at the ti vestigation, in my	me, date and place	ce, and due to the curred at the time	cause(s) and n , date and place	manner as state, and due to the	ed. ne cause(s)
	Medical Certifica	4 ☐ Homicide  29a. Certifier (Check only	1 Certifying 2 Medical Ex	Physician: To the be	of examinat	wledge, death tion and/or in	n occurred at the ti vestigation, in my	opinion, death oc	ce, and due to the curred at the time	cause(s) and n , date and place 29d. Date sign	e, and due to th	ne cause(s)
To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the f		4 ☐ Homicide  29a. Certifier (Check only one)	1 Certifying 2 Medical Ex	Physician: To the be	of examinat	wledge, death	vestigation, in my	opinion, death oc	ce, and due to the curred at the time	, date and place	e, and due to th	ne cause(s)
To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the formal Professional Completely filled in by the formal Professional		4 ☐ Homicide  29a. Certifier (Check only one)	1 Certifying 2 Medical Ex	Physician: To the becaminer: On the basis and manner	of examinat	tion and/or in	29c. Licens	opinion, death oc	ce, and due to the curred at the time	, date and place	e, and due to th	ne cause(s)
To the Hospital or Attend within 24 hours after death.  To the Funeral Director: A completely filled in by the filled in by t	Medical	4 Homicide  29a. Certifier (Check only one)  29b. Signature and	determined  1 Certifying 2 Medical Extension  determined  tress of person with	Physician: To the becaminer: On the basis and manner	s of examinal stated.	tion and/or in	29c. Licens	opinion, death oc	See, and due to the curred at the time	, date and place	e, and due to th	ne cause(s)

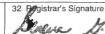
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death 2008 Year **Physician** Month February 11:10 P M Iskra Tsoi /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery | HUnder 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept 7, 9. Birthplace (State or Foreign Country) Uzbekistan 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 🔀 F Director 219-59-8794 63 Usual Residence of Decedent the Maryland a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 14 Yes 2 □ No Director MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Medical Examiner must be n 17060 King James Way Apt 620 20877 Uzbekistan by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: 3 Widowed 4 Divorced Asian Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Economist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gregory Tsoi Nadejzda Kim 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15425 Reprise Terrace Rockville, MD 20850 Lev Tsoi/brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Chesapeake Crematory | 02/05/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a. Pancreatic Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Under in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Vear 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2XNo 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 2<del>√</del> No Yes Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other:  $_{4\square \, \text{Nursing Home}}$  5  $\square \, \text{Residence}$  6  $\square \, \text{Mother} \, \text{(Specify)} \, \text{hospice}$ 1 ☐ Yes 2 X No Hospital: Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death. 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Funeral 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely and manner stated.

within 2 To the

State Registrar

Génevieve Wroblewski, M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855 31. Date filed (Month, Day, Year) FEB 05 2008

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D64615

29d. Date signed (Month, Day, Year) February 3, 2008

Division or Vital Records, P.O. Box 68760.

completely filled in by the funeral within 24 hours after death. To the Funeral Director: After To the Hospital

> 5 State

> > Registrar

Medical

31. Date filed (Month, Day, Year) 2008 1AN 3 1

29b. Signature and title of certifie,

29a. Certifier



and manner stated.

(Georg )

1 FCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D19318

29d. Date signed (Month, Day, Year) JANUARY 30,2008

7. Age (In yrs. last birthday)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Silver Spring

2. Date of Death

January

Month

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 No

New York

31, 2008 12:53 p

Montgomery

4c. County of Death

USA

Specify:

14. Race - American Indian.

**Black** 

Black, White, etc.

Television News

23d. Date of delivery

29d. Date signed (Month, Day, Year)

February 1, 2008

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1941

0		9		7
3 T	ime	of D	eath	

**Physician** /Medical Examiner

**Funeral** 

1. Decedent's Name (First, Middle, Last)

Louis Taylor

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

Paul

5. Social Security Number

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Saheed Kronfli, MD

FEB 0 4 2008

30. Name and andress of person who completed cause of death (Item 23a) (Type, Print)

💓. Registrar's Signature

State

Registrar

29c. License number

1500 Forest Glen Road, Silver Spring, MD 20910

D41662

08-0085	57	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

asiiawiida ivi.		1- For State Registrar	Certifi	icate of D			Reg.	No. 2	is algl		
Physici Medical Exami		Decedent's Name (First, Middle, Last)     La Shawnda Makeisha	Tate				2. Date of Death  Month  January 31,	Day Year 2008	3. Time of Death 0015 hrs		
		4a. Facility Name (if not institution, give street an 5006 57th Avenue Apt. C4	d number)		City, Town, or Bladensbur	Location of Death		4c. County of Death			
Funeral Director		5. Social Security Number 6. Sex 1 M 2 M	7. Age (In yrs. last b	· · ·	f Under 1 Yea Months Day	<del></del>	8. Date of Birth (	(MM/DD/YYYY) 9. Bir Foreig Co	thplace (State or on Washington, DC untry)		
id how any cc.	_	Usual Residence of Decedent  10a. State  10b. County  Maryland  Prince Georges		wn or Location					10d. Inside City Limits 1 X Yes 2 No		
th the Maryland 23a or 28a-f show any notified at once.	Director	10e. Street and Number 5006 57th Ave., Apt. C-4		10	of. Zip Code 20710			. Citizen of What Cou	ntry?		
r death wi or items	by Funeral	1 XX Never Married 2 Married Arme		If Yes,	specify Cubar	spanic Origin? (Sp n, Mexican, Puerto specify: tion (Give kind of v	Rican, etc.)	14. Race - Amer White, etc.  Specify: Blace  6b. Kind of Business/			
215-0036 be filed within 72 hours afte ntal Hygiene rked other than "natural". ent, the Medical Examines	Completed		ge (1-4 or 5+)		of working life	. DO NOT use retir	red)	Dental Offic	717		
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	17. Father's Name (First, Middle, Last) Ernest	Tate		-, H1	18.Mother's Name Gladys		Dempsey			
nore, MD 21 ages 1 and 2 should nt of Health and Me nt: If item 27 is man other traumatic ev	To	19a. Informant's Name/Relationship (Type, Print Ernestine Dempsey - Grandin 20a. Method of Disposition	other 2		del Rd.	#4, Mt. Ra	inier, MD	er, City or Town, State  20712  20c. Location - City or			
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr			al from State cren	natory or other rection (	place) Lemetery	2/9/	2008	Clinton, MD s Funeral Ho			
		Efer V. Rules	not caused the death. Do	6160	Oxon Hil	Ll Rd., Oxo	n Hill, MD	20745	Approximate Interval		
Physician /Medical aminer	8	23a. Fart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):									
ed nsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or	as a consequence of):								
60, ate be execui hysician and e burial - tra	edical	d. UNPENDED AMEND	220					1			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 butus after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	yes, outcome of pregnan live birth Pregnant at time of death Jnknown	2 Fetal	death 3 (Specify)	Ectopic pregna	ancy		Day Year		
, P.O. E ires that the c signed by the lbe detached	by	Part II. Other significant conditions contribut	ing to death but not resul	Iting in the und	erlying cause	given in Part I.		eacco use contribute to 2 ✓ No 3 Pro	o the cause of death?		
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ital   sician: s certifi irector,	Be	25. Was case referred to medical examiner? Hospital: 4	Inpatient 2 ER	R/Outpatient 3		of Death (Check		Residence 6 🗸 Othe	er: Scene		
on of V nding Phys th r: After thi	ion: To	1 ✓ Yes 2 No  27. Manner of Death  1 Natural 5 Pending Jan	Date of Injury 28	359 hrs	ry 28c. Inju	ury at Work? Yes 2 ✓ No		ow injury occurred			
Division intal or Atterns after des rail Directo	Certification:	Suicide Could not be	Place of Injury - At home		factory, office		or Town, Sta		tural Route Number, City		
o the Hosp Aithin 24 ho To the Fune	Medical C	29a. Certifier 1 Certifying Physician: To the (Check only one) 2 Medical Examiner: On the b	e best of my knowledge, asis of examination and/ ner stated.	death occurred	d at the time, o	late and place, and n, death occurred a	due to the cause at the time, date a	(s) and manner as stand place, and due to t	nted. he cause(s)		
F 3 F 3	Œ	29b. Signature and title of certifier			29c. Licen			29d. Date signed (M			
R(3)		30. Name and address of person who completed Ling Li, MD Assistant Medical B				.M.E.		January 31, 200			
	tate	31. Date filed (Month, Day, Year)	2. Registrar's Signature	Crim Otreet,	Daramore,	WID 2 1201					
Regis	trar	FEB 0 4 2008	1 I AD	342							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 30 2008 11:55 PM JANUARY **TAYLOR** M. WILLIAM /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** PRINCE GEORGE'S FT. WASHINGTON FT. WASHINGTON HOSPITAL 8. Date of Birth (Month, Day, ) OCT • 19 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Days Months Hours Min. MARYLAND 1 X M 2 □ F 1921 86 Director 577-26-5025 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director PRINCE GEORGE'S OXON HILL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA STREET # T-1 20745 KENNEBEC Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married BLACK 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ified within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi:
Department of Health and Mental Hygien
Important: If item 27 is marked other the
any Injury or other traumatic event. the TRASH INCENERATOR GOVERNMENT 4th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MAUDE HODGE MAURICE N. TAYLOR ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 1124 KENNEBEC ST # T-1 OXON HILL MARYLAND 20745 MARION TAYLOR/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State 2/7/2008 SUITLAND, MARYLAND LINCOLN CEMETERY 4 Donation 5 Dother (Specify) J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OF monta **Physician** /Medical Due to (or as a consequence of): NCER OF PANCREAS **Examiner** USP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine EPSIS the burial-trai Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>6</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No DIABETIS 2 No 1 ☐ Yes 1□ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: n 24 hours after death.

ne Funeral Director: 
A pletely filled in by the fi

within 2 AC.

State Registrar

Medical

29a Certifier

6196

31. Date filed (Month, Day, Year)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 20024064

OXON HILL 2074

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01081		State of Maryland / Department of I	Hoalth and Mental Hy						
gela Townser		State of Maryland / Department of larger state of Maryland / Department of larger state of lar							
		Registrar  1. Decedent's Name (First, Middle,Last)		Reg. No. 2. Date of Death 3. Time of Death					
Physici edical Exami		Angela Pamela Townsend		Month Day Year 0220 hrs February 7, 2008					
			o. City, Town, or Location of Death	4c. County of Death					
		Prince George's Hospital Center	Cheverly	Prince George's					
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs.	8. Date of Birth (MM/DD/YYYYY) 9. Birthplace (State or Foreign					
Director		577 92 1229 1 M 2 XX 44 Yrs.	Months Days Hours Min.	May 16 1963 Country Washington					
		Usual Residence of Decedent	<u> </u>						
any		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 Yes 2 V No					
nd show	۱ ا	Maryland   Prince George's   Fort Wa	washington						
laryla	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?					
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. them 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once.	ä	505 Round Table Drive	20744	United States					
with with as 23.	rai		Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.					
death r iten	Funeral	1 Never Married 2 Married 1 Yes 2 VVNo	s, specify outstif, McXiddif, 1 dorlo						
after and after on the ner n	by F	3 Widowed 4 Y Divorced If Yes, Give Year or Dates:	Yes 2 No specify:	Specify: Black					
5-0036 led within 72 hours a Hygiene. tother than "natura th. Medic I Examir	d be	during mo	's Usual Occupation (Give kind of worst of working life. DO NOT use reti	vork done 16b. Kind of Business/Industry red)					
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5-0036 fled within 7/ Hygiene. I other than	Completed	12 4 Cleri	La Mothor's Name	Geneology (First, Middle, Maiden Surname)					
5-C		17. Father's Name (First, Middle, Last) James Foley Barnes, Sr.	E1 i	zabeth G. Butler					
ID 21215-0036 2 should be filed within 72 and Mental Hygiene. 27 is marked other than matic event, the Medical	o Be		version in version black in a commercial	Rural Route Number, City or Town, State, Zip Code)					
Should mid M is m affe of	۲	Calvin Henry (SON) 2905	Enterprise Roa						
MD and 2 sho saith and 27 is raumati		, , , , , , , , , , , , , , , , , , , ,	tion (Name of cemetery,	d. Bowie, MD 20721  Date 20c. Location - City or Town, State					
S 1 S 1 S 1 S 1 S 1 S 1 S 1 S 1 S 1 S 1		1 Burial 2 Cremation 3 Removal from State crematory or oth	ner place)	18-2008 Clinton, Maryland					
Baltimore permit. Pages 1 Department of H Important: If injury or other			on Cemetery						
salt rmit. eparti nporti		21.019.74.01	ame and Address of Facility Le	e Funeral Home, Inc 6633 01d					
m gore		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	Lexandira Ferry	Road, Clinton, MD 20735					
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	le mode of dying, such as cardiac c	Between Onset and Death					
/Medical aminer		Immediate Cause (Final disease a. Alcohol intoxication		Book.					
		or condition resulting in death)  Due to (or as a consequence of):							
	<u>.</u>	Sequentially list conditions, if any, leading to immediate b							
	miner	cause. Enter Underlying Cause [Disease or injury that initiated	922						
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n of Vital Records, P.O. Box 68760, ding Physician: The law requires that the death certificate be h. After this certificate has been signed by the attending physici finneral director, page 2 should be detached for use as the burn.	sician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery ancy Month Day Year					
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ires that the signed by I be detach				1 Yes 2 No 3 Probably 4 ✔ Unknown					
ds, equire een si	ompleted			24a. Was an 24b. Were autopsy findings available prior to completion of cause of					
Or law re has be 2 she	ਵ			performed?					
Rec The icate	5		00 DI	1 Yes 2 No 1 Yes 2 No					
Vital Rec ysician: The his certificate director, page	B B	25. Was case referred to medical examiner? Hospital: 1 Inspiral: 2 FR/Outnatient	26.Place of Death (Check						
Vit hysic this	ြို	1 Ves 2 No Inpatient 2 ER/Outpatient		ing Home 5 Residence 6 Other:  28d. Describe how injury occurred					
1 of V Jing Phy L. After tl funeral	٦	27. Manner of Death 28a. Date of Injury (Month, Day, Year)  Natural 5 Panding (Month, Day, Year)	1 Yes 2 No						
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Division of Vital Records, tal or Attending Physician: The law requires after death. After this certificate has been side in by the funeral director, page 2 should be in by the funeral director, page 2 should be	] 🖺	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, stree	et, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
E G Di	: I O			6819 W. Forest Rd. Landover, MD					
t Hos 24 hr	, –	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur one)  Wedical Examiner: On the basis of examination and/or investiga	rred at the time, date and place, an	id due to the cause(s) and manner as stated.  at the time, date and place, and due to the cause(s)					
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation and manner stated.							
	ĮΣ	29b. Signature and title of certifler	29c. License number	29d. Date signed (Month, Day, Year)					
		Com Winh	O.C.M.E.	February 7, 2008					
		30. Name and address of person who completed cause of death (Item 23a)							
		Donna M. Vincenti, MD Assistant Medical Examiner 117	1 Penn Street, Baltimore, I	MD 21201					
	State	31. Date filed (Month, Day, Year) 32. Segistrar's Signature	016 J						

Registrar

			For State Registrar	State of M	arylan	d / Depa	artment of F rtificate of	lealth and N Death	Mental Hy	giene	2008	04951
			Hegistrar  1. Decedent's Name (First, Middle)			001	incate or		2. Date of De	3		3. Time of Death
	Physic			Jin Sup Um					Month January	Day 29	Year 2008	9:58 рм
Acres 1	/Medi Examii		4a. Facility Name (If not institution				4b. City, Town, o	r Location of Death			County of Death	
			Shady Grove Adv	entist Hospital				Rockville			Montg	omery
	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th av. Year)	9. Birth	place (State or Foreign ntry)
	Director		217-94-1551	IXIM ZUF	71	Yrs.			February			Korea
	and w		Usual Residence of Decedent  10a. State 10b. Count	y	10c. City	, Town or Lo	cation					10d. Inside City Limits
	Mary f sho	ō	Maryland M	ontgomery				larksburg				1 □Yes 2K No
	r 28a	Director	10e. Street and Number	onegomery			10f. Zip Code	Tarksburg		10g. Citiz	zen of What Cou	ntry?
	h with	<u>=</u>	12885 Murphy G	rove Terrace				20871			U.S.A	
	deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S	S. 13.	Was Decedent of H If Yes, specify Cuba		pecify Yes or No	)- 1	14. Race - Ameri Black, White	can Indian,
98	after or its	F	1 ☐ Never Married 2 ☒ Ma	rried 1 Yes 2 X			1 □ Yes 2 ☒ No	Specify:	o riican, etc.;		Specify:	
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show tikal Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorce	d Year or Dates:								Asian
15	n 72   "nat die	lete	(Specify only high	nt's Education est grade completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of work d)	king	16b. Kir	nd of Business/Ir	ndustry
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p	illed I Hyg other	Be C	17. Father's Name (First, Middle	, Last)				18. Mother's Nam	ne (First, Middle		-	
Maryland	uld be Jenta Irked tic ev	To B	Unknown	Um				Bok Soc	on Lee			
ary	should be and be should be		19a. Informant's Name/Relation	ship (Type. Print)		19b. Mailir	ng Address (Street	and Number or Ru	ral Route Numb	er, City or	r Town, State, Zi	p Code)
Σ	and 2 eafth n 27 I		Shin Ja Um -	Spouse			Murphy Gro		, Clarksb	urg, M	Maryland 2	0871
ore	ges 1 of He if iten or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation	3 □Removal from State	20b. Pl	ace of Dispo emetery, crei	sition (Name of natory or other plac	ce)	Date	20c. Lo	cation - City or T	own, State
Ë	Pagiment		4 □ Dopation 5 □ Other (		I .	Lincol	n Cremator	y 02/0	2/2008	Bren	twood, Ma	ryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the M. di. al Examiner must be notified at once.		21. Signature of Funeral Service	Licebsoo		H:	2. Name and Addre ines-Rina1d	i Funeral H				
	-1-46		23a. Part1. Inter the disea e, shock, or heart failure. Lis	r complication: that cause	d the death						ring, Mar	yland 20904 Approximate
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	/Medical		resulting in death)	a. Acute Due to (or as			farction					1 hour
М	Examiner		Sequentially list conditions,	b. Corona:	ry Arte	ery Dise	ease					Years
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68760,	death certificate be executed e attending physician and of for use as the burial-transit	edical Examiner		d.	·	, 						
68	rtificating phy as th		15 55 M #									
Вох	th cer lendir r use	an/l	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 □Live birth			Ectopic pregnancy	,		2	23d. Date of deliv	
O. E	0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of de		Other (specify)	'			Month	Day Year
P.0	res that the de signed by the a be detached t		Part II. Other significant condit	ions contributing to death b	out not resu	Iting in the u	nderlying cause give	en in Part I.	23e. Did t	tobacco us	se contribute to	the cause of death?
or Vital Records,	law requires that the as been signed by th 2 should be detache	d by			_	_			10	Yes 2	□ No 3 □ Pro	bably 4 ⊠Unknown
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Re	0 <u>c</u> 0	E O							auto perfo	rmed?	prior to co death?	ompletion of cause of 2□ No
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Ž V	di is	ToE	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatio	ent 2🖺 E	ER/Outpatien	t 3 DOA Oth	er: 4 🗆 Nursing H	ome 5 ☐ Resi	dence 6	3 □Other (Speci	fy)
	ng ifter		27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	28a. Date of Inju		28b. Time of Injury	28c. Injur Worl	y at k?	28d. Describe	how injury	y occurred	
Sio	r Attending er death. rector: After by the funer	cati	2 ☐ Accident invest 3 ☐ Suicide 6 ☐ Could	not be 200 Bloom of ini	um. At hon			Yes 2 ☐ No	001			
Division	al or A s after of at Direct ed in by	Certification:	4 ☐ Homicide determ	nined   Zoe, Flace Ut III]	tc. (Specify	ne, rami, str	eet, factory, office		City or To			al Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 ☑ Certifyi (Check only one) 1 ☑ Medica	ng Physician: To the best I Examiner: On the basis of and manner st	of examinat	vledge, death ion and/or in	n occurred at the tirvestigation, in my o	me, date and place ppinlon, death occu	, and due to the rred at the time,	cause(s) date and	and manner as	stated. to the cause(s)
	To th within To th	Me	29b. Signature and title of certific	er			29c. Licens	e number		29d. Date	e signed (Month,	Day, Year)
	12		1/2/2.1	3 - M	10		DO	064235		Jan	uary 29,	2008
,			30. Name and address of person	who completed cause of c	leath (Item	23a) (Type,	Print)					
	-		Joel E. Buzy, M					le, Marylan	nd 20850			
V.	Sta Registr		31. Date filed (Month, Day, Year	2008 Segistr	ar s signar	ure A	wei					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death I. Decedent's Name (First, Middle, Last) Day Month Year Physician 2, 2008 1:10 February Eleanore Flory Voss /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring Aspenwood Senior Living If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 1 F 1913 May 17, Missouri 579-10-6617 94 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2x No Director Montgomery Silver Spring Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20906 USA 14400 Homecrest Road, Apt. 44 Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes 2 No Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🛂 No Specify: White Specify: If Yes, Give Year or Dates: þ 3√XWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) in and 2 should be filed within Health and Mental Hygiene. tem 27 is marked other than ' College (1-4or 5+) Elementary/Secondary (0-12) Federal Government 1 Personnel Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stella Dean Hubbard Harry J. Flory ပ 20904 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Constance M. Ewy/Friend 3146 Gracefield Road, Apt. 31, Silver Spring, MD item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1 Department of He Important: If iten 4, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Feb. ö Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) in)ury 2008 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 Universtiy Blvd, West, Silver Spring, MD 20901 23a. Part1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Immediate Cause (Final **Physician** Failure To Thrive resulting in death) /Medical Due to (or as a consequence of): Examiner Advanced Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 ☐ Unknown Psychosis, Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 2 X No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 10 Other (Specify Assisted 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 X No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Living Injury 5 Pending XX Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: All completely filled in by the fu investigation 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide

4 Homicide

6 ☐ Could not be determined

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

NO

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18111 Prince Philip Drive, #101, Olney, MD 20832 Ata Motamedi, MD

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a, Certifier

(Check only one)

Medical

State

Registrar

FEB 0 5 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 12:55 AM William Garrett Van Meter 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville 8. Date of Birth (Month, Day, Year, Dec. 18, 1 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1918 West Virginia 578-44-7913 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Montgomery Gaithersburg 1 ☐ Yes 2 No 10f. Zip Code 20882 10e. Street and Number 10g. Citizen of What Country? 9431 Warfield Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No 1940 If Yes, Give Year or Dates: 1940 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1942 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced White 1945 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) U.S. Chamber of College (1-4or 5+) 5+ Elementary/Secondary (0-12) Executive Vice President Commerce 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Gilkeson Van Meter Nellie Dinges 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9431 Warfield Road, Gaithersburg, MD20882 Bonnie Jean Van Meter (Wife) 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Gace of Heaven 1 ☑ Burial 2 ☐ Cremation 3 Removal from State February Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 2008

**Physician** /Medical Examiner

**Physician** 

Examiner

**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

/Medical

Directo

Funeral

Completed by

Be

2

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit one process. certificate has b irector, page 2 s

Division or Vital Records, P.O. Box 68760,

	21. Signature of Funeral Service Lice	ersee	22. Nar	ne and Address of Facility $ { m D}  { m c}$	eVol Fune	ral Home		
	May.	) Was	10 E	. Deer Park Dr	ive, Gait	hersburg,	MD 20882	
	23a. Pa 1. Enter the ise se, or co shock, or heart ailu List onl Immediate Cars. Pin disease or condition resulting in death)	mplications that caused the death. A no yone cause on each line.  a. RESPIRATORY	FAIL		c or respiratory arre	st,	Approximate Interval Between Onset and Death	
Ц	resulting in death)	Due to (or as a consequence of	,					
	Sequentially list conditions	b. ASPIRATION	_	FUMONIA				
ne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of	):					
Examiner	that initiated events	c						
Ж	resulting in death) Last	Due to (or as a consequence of	):					
ca		d						
Jed	IE EEMALE.					1		
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   23d. Date of deliver Month   23d. Date						elivery Day Year	
7	Part II. Other significant conditions	acco use contribute	to the cause of death?					
d by							Probably 4 <b>⊡</b> Únknown	
plete						24a. Was an 24b. Were autopsy findings availab		
Completed					perform	autopsy prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No		
Re	25. Was case referred to medical examiner?				ath (Check only one			
0	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	atient 3[	DOA Other: 4 Nursing F	łome 5 ☐ Resider	nce 6 □Other (Sp	ecify)	
ation:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending  2 ☐ Accident investigation			28c. Injury at Work?	28d. Describe ho	w injury occurred		
Certification:	3 Suicide 6 Could not 4 Homicide determined	n, street, fa	actory, office	28f. Location (Str. City or Town,	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner and due to the cause(s) and due to the cause(s							as stated. ue to the cause(s)	
Ž.	29b. Signature and title of certifier			29c. License number	29	d. Date signed (Mor	nth, Day, Year)	
	Ma man k	mobile mo		D0062562	- Fe	BRUARY (	2008	
	30. Name and address of person who	completed cause of death (Item 23a) (Ty		NTER OR ROW	Brank 1 = A	A (20 M) (4-10	3:20/2-	

State

Registra

31. Date filed (Month, Day, Year)

FEB 0 5 2008

Registrar's Signature

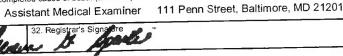
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04954 2008 State of Maryland / Department of Health and Mental Hygiene William Arthur Van Croft, III Certificate of Death 1- For State Reg. No. 3. Time of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day January 31, 2008 Physician/ 0831 hrs William Arthur Van Croft, III √ Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Upper Marlboro Northbound Route 301 and Osbourne Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) Foreign Washington 5. Social Security Number **Funeral** Hours Days Months May 17, 1964 43 Director 577-04-9333 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No Washington District of Columbia or items 23a or 28a-f show must be notified at once. filed within 72 hours after death with the Maryland 10g. Citizen of What Country? Director 10f. Zip Code 10e. Street and Number United States 20012 1375 Locust Road, NW 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S Funeral 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 Married 2 X No Yes Specify: Black Yes 2 X No specify: If Yes. Give Year 4 X Divorced 3 Widowed event, the Medical Examiner "natural" ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Self Employed Appliance Repairman 21215-0036 3 years Pages 1 and 2 should be filed within tent of Health and Mental Hygiene. int: If item 27 is marked other th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruby M. Rainey William A. Van Croft, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1375 Locust Rd., NW Washington, DC 20012 9 Ruby M. Van Craft - Mother 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) rtant: If its X Burial 2 Cremation 3 Removal from State Feb. 7, 2008 Suitland, MD incoln Mem. Cemetery Donation 5 Other Specify 2. Name and Address of Facility Stewart Funeral Home, Inc. permit.
Departm
Imports
injury o ignature of ral Service Lic ns 4001 Benning Road, NE Washington, DC 20019 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Between Onset and Physician failure. List only one cause on each line. Death **ledical** a. Multiple Injuries Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami Due to (or as a consequence of): and transit Hospital or Attending Physician: The law requires that the death certificate be executed cal AMENDED UNPENDED attending physician or use as the burial sician/Medi 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IE FEMALE Year Month Day 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ę, o 1 Yes 2 V No 3 Probably 4 Unknown ò σ. Completed 24b. Were autopsy findings available 24a. Was an Records. prior to completion of cause of certificate has been autopsy death? performed? ✓ Yes 2 1 🗸 Yes page 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other: Nursing Home 5 Residence 6 Other: Scene Hospital: examiner? ER/Outpatient 3 Inpatient 2 this 1 Yes 2 No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury 28b. Time of Injury 27. Manner of Death After Pedestrian struck by auto Certification: Jan 31, 2008 0824 hrs Yes 2 V No Natural Pending Director: death 28f. Location (Street and Number or Rural Route Number, City 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. n 24 hours after d e Funeral Direc or Town, State) Northbound Route 301 and Osbourne Road, Upper Marl Could not be Suicide determined (Specify) Major Road / Highway Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Che To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number

FEB 0 5 2008

Pamela E. Southall, MD

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier



**OCME** 

February 1, 2008

State Registrar O.C.M.E.

		State of Maryland / Department of Health and M  1 - State Certificate of Death	ental Hygier	- / 11117	3 04955
		Registrar  1. Decedent's Name (First, Middle, Last)	2. Date of Death	10.	3. Time of Death
Physici	an	James John Watt	Month February	2, 2008	8:55 a M
/Medi		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Dea	
Examir	ier .	aa. I acinty Name (ii not institution, give sheet and		Monto	gomery
-		5 Social Sequitiv Number 6, Sex 7, Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea		rthplace (State or Foreign
Funeral Director		1	May 6, 19		ndiana
		Usual Residence of Decedent			
rylan how		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
e Ma a-f s tified	cto	Maryland Montgomery Rockville			
or 28	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What C	ountry?
ath w		4841 Flower Valley Drive 20853	neify Ven ex No	USA 14. Race - Am	erican Indian
er de	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Wh	
s afte	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No   1 □ Yes 2 □ No   1 □ Yes 2 □ No   Specify: 3 □ Widowed 4 □ Divorced   Year or Dates: WWII		Specify:	White
hours tural",		15. Decedent's Education 16a. Decedent's Usual Occupation		. Kind of Busines	s/Industry
in 72 n "na Medic	plet	(Specify only highest grade completed) (Give kind of work done during most of work)  [Give kind of work done during most of work)  [Give kind of work done during most of work)  [Give kind of work done during most of work)	N.		esign & Developme
Id I yid II Z I Z I D-DUDO 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12)  College (1-4or 5+)  Mechanical Engines	er Nuc	lear Power	Salety
illed Hyg other	Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name	(First, Middle, Maid	den Surname)	
Id be file fental H rked oth	O I	Harry Davidson Watt Flora Kathe	erine Cook	2	
shou and N s mai	r	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rura	al Route Number, Cit	ty or Town, State,	Zip Code)
and 2 alth a 127 I		E. Jane Watt/Wife 4841 Flower Valley  20b. Place of Disposition (Name of	Drive, Ro	ckville	MD 20853 or Town, State
of He of He of He of He of He		20a. Method of Disposition  1 □ Bunal 2X□ Cremation 3 □ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  Fet		. Location - City o	ir Town, State
antilion mit. Pages partment of portant: If it y injury or o	Ш	Walter and Table and American	2008 Ale	exandria	, Virginia
perilliniole, Inial yialla ZIZIS-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility  Francis J. Collins	Funeral H	iome Inc	
0 82E 8 8		Source   500 University Blvd	d, W., Sil	lver Spr	ing, MD 20901
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.	or respiratory arrest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition a Multiple Myeloma			4½ months
/Medical		Due to (or as a consequence of):			
Examiner	l.	Sequentially list conditions, b.			<u> </u>
Sit %d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
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w requires that the death certifications as signed by the attending to should be detached for use as	Physician/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy		23d. Date of d	lelivery
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the d	ysi	1 Yes 2 No 9 Unknown			
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uires uires Islan	d by	Shy Drager Syndrome, Parkinson's Disease	1 ☐ Yes	2 X No 3 □	Probably 4 □Unknown
v req beer shou	ete		24a. Was an	24b. Were	autopsy findings available
The law requires the has been sign	Completed		autopsy performed	d? death	o completion of cause of ? es 2 ☐ No
	ပ္ပိ	25. Was case referred to medical 26. Place of Death	1   Yes 2€5 h Check on one	(NO   ILLI	es 2 140
Or VILA Physician: this certific ral director,	o B	examiner? Cher.	ome 5 🔀 Residenc	e 6 □Other (S)	pecify)
Phys Phys er this		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how i		
LIVISION I or Attending after death. Director: Afte	tio	1 StNatural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
Atter r dear	ifica		28f. Location (Stree City or Town, S	t and Number or	Rural Route Number,
allor din t	Certification:	4 Inditioned	ony or rowing o		
ospita hours inera y fille		29a. Certifier (Check only (Ch	and due to the caus	se(s) and manner	as stated.
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	one) and manner stated.			
To the withing the To the Complex comp	ž	29b. Signature and title of certifier		Date signed (Mo	onth, Day, Year)
WAL		D2105	1 1	4/4/	- 0'
101		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	an of	1033	
		Jonathan Maltz, MD 2901 Olney-Sandy Spring Road, Oln	ney, MD 20	J63Z	
	ate	31. Date filed (Month, Day, Year) FEB 0 5 2008  3 Registrar's Signature			
Regist	rar	LED 0 0 5000 Marino 10			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** LEAH A. WOODALL 2,2008 10:10 A FEBRUARY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BERLIN NURSING HOME WORCESTER BERLIN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-15-1964 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🕅 F Days Hours 43 Director 216-92-8075 MARYLAND Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f shedical Examiner must be notified 1 ☐ Yes 2 No Director DELAWARE SUSSEX FRANKFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 37540 OAK STREET 19945 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 XX No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify ò WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

SECRETARY and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) PRINTING 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM PRICE LEONA GORSKI ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a DONALD E. WOODALL/ HUSBAND 37540 OAK ST, FRANKFORD, DELAWARE, 19945 20b. Place of Disposition (Name of MELSONS CAPE HENLOPEN CREMATORY 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 ☐Removal from State 4 □ Donation 5 □ Oner (Specify) 2-4-08 FRANKFORD, DELAWARE ure of Fu 21. Signal 22. Name and Address of Facility
MELSON FUNERAL SERVICES, LTD.
WEST AVENUE, OCEAN VIEW, DELAWARE. 19970 a ear complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part1. E 1 the dise shock, or heart failur Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant signed by the atter of be detached for u 3 □ Ectopic pregnancy in the past 12 months? 1☐ Yes 2 No 4☐Pregnant at time of death 9☐Unknown Month Year Day 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 1□ Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After To the Hospital or Attending within 24 hours after death. 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year)

Registrar

State

Ne Mary S 31. Date filed (Month, Day,

FEB 0 6 2008

BA II

WOODALL

who completed cause of death (Item 23a) (Type,

32. Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year)

FEB 0 6

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend#19b.PerFHPCC2-12-08cr For Ameno#190.Petrum. State Registrar Ameno#8.PerFHPC2-11-08cm Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 02/03/2008 22:35 John Elliott Wright /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Prince George's Community Hospital Cheverly 8. Date of Birth 3—2—1936 (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1⊠M 2□ E Fort Motte, SC 251-54-2625 71 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 1X Yes 2 No Director Prince George's MD Springdale 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or Items 23a or 9203 Gary Lane 20774 USA death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iten any Injury or other traumatic event, the Medical Examines once. 1⊠Yes 2□No 1960-If Yes, Give Year or Dates: 1965 1 ☐ Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify. þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Night Operations Coordinator Grocery Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Wright Elnora Wilson ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20774 <del>20744</del> 9203 Gary Lane, Springdale, Loretta Wright / wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Brentwood, MD 4 Donation 5 Other (Specify) Ft. I.incoln Cemetery 02/08/2008 21. Signature of Funeral Service Licensee Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIOMYOPATHY Physician /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and the burial-transi VENTRICULAR Due to (or as a consequence of) Box 68760, Physician/Medical attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use Intribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 / No 3 Probably 4 Unknown 1 ☐ Yes Completed 4b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I rector, page 2 s autopsy 2 No 2 🗆 No 1 □Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident s after death. 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. Liçense number 29b. Signature and little of certifier 10062141

State Registrar

Oulinde Coker, 3001 Hospital Drive, Cherverly, MD 20785 31. Date filed (Month, Day, Year) FEB 0 7 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** GABRIELLE WRIGHT FEBRUARY 4 2008 2:50 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MANOR CARE NURSING HOME PRINCE GEORGE'S LARGO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 <del>y</del> F 92 MARYLAND 213-12-1293 JULY 4 1915 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Director MD PRINCE GEORGE'S MITCHELLVILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 10108 BALD HILLROAD 20721 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" or Item any Injury or other trainmain. 1 □ Never Married 2 □ Married BLACK 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ 3X1Widowed 4 □ Divorced Year or Dates Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) HOME MAKER PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ JOHN H. DAVIS CARRIE JONES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) CAROLYN WILSON/DAUGHTER 10108 BALD HILL ROAD MITCHELLVILLE, MARYLAND 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Bunal 2 □ Overnation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) HARMONY CEMETERY 2/11/2008 LANDOVER, MARYLAND Other (Specify 22. Name and Address of Facility 21. Signature of Funeral Service Lice J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Ganarene disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Examine The law requires that the death certificate be executed *teripheral* artery Disease burial-tran Due to (or as a consequence of) attending physician for use as the buria Dementia Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 2 Fetal death Month Year in the past 12 months?
1 ☐ Yes 2 ☐ Who
9 ☐ Unknown Day 4 ☐ Pregnant at time of death 5 Other (specify) detached 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 1 TYes 2√∑ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA ို 1 ☐ Yes 2 X No 1 🗌 Inpatient 2 ER/Outpatient this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 27. Manner of Death 28c. Injury at Work? After (Month, Day Year) 1X Natural 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: filled in by e Funeral i πpletely the

> State Registrar

Medical

29a. Certifier

29b. Signature and title of oe

31. Date filed (Month, Day, Year)

FEB 0 7 2008

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 7

2

DONALD GEORGE M.D. 7500 HANDOVER PARKWAY SUITE 101A GREENBELT, MARYLAND 20770

ī 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

			1- State of Maryland / Def. State of Maryland	epartment of Health and N Certilicate of Death	Mental Hygie	ne . №2 () () ()	04960
	Physici /Medic		Decedent's Name (First, Middle, Last)  JAMES RUFUS WHITE		2. Date of Death Month FEB 5 20	Day Year	3. Time of Death  1:28 A M
0.00	Examin		4a. Facility Name (If not institution, give street and number)  NATIONAL NAVAL MEDICAL CENTER	4b. City, Town, or Location of Death		4c. County of Death	
	Funeral Director		5. Social Security Number  236464837  6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	707	nplace (State or Foreign untry) field, <del>Va</del>
	e Maryland a-f show tifled at	ctor	Usual Residence of Decedent  10a. State  10b. County  Maryland  Prince George's  Capitol				10d. Inside City Limits 1 → Yes 2 No
	th with the 23a or 28 ust be no	al Directo	10e. Street and Number 6816 Wilburn Drive	10f. Zip Code 2 <del>0731</del> 20743	Un	. Citizen of What Co	es
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If tem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 √√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√	pecify Yes or No- p Rican, etc.)	14. Race - Amer Black, White Specify: Bla	e, etc.
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Maryland	2 should be and Mental set is marked or raumatic ever	To	Willie White William White  19a. Informant's Name/Relationship (Type. Print)  19b. I	Maude M  Mailing Address (Street and Number or Ru		City or Town, State, 2	(ip Code)
	1 and 2 s Health ar tem 27 is		Rosa White / Wife 6816	Wilburn Dr. Capito	l Heights	207 Md. <del>207</del> c. Location - City or	<del>3</del> 1
Baltimore,	t. Pa rtmer rtant:		Nemoval from State	con National 2/22/		lington,	
Ba	permi Depar Impor any Ir		Stute a Same MULES	22. Name and Address of Facility Po 5538 Marlboro Pike	•	•	
) dest	Physician /Medical		23a. Part1 Emer the disease, or complications that aused the death. Do no shock, or heart failure. List only one cause on each line.  Immediate Ceuse (Final disease or condition a. PNEUM resulting in death)	IONIA	or respiratory arrest	t,	Approximate Interval Between Onset and Death
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	ecuted and I-transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of c				
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Vita	iclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	Other	th (Check only one)		
on or	Attending Physician: r death. ector: After this certific. by the funeral director,	tion: To	27. Manner of Death 1 S Pending (Month, Day Year)  1 S Pending (Month, Day Year) 1 S Pending (Month, Day Year)	Attent 3 DOA 4 Nursing H	ome 5 ☐ Residence 28d. Describe how	ce 6 Other (Spe injury occurred	cify)
Division	or Atten after deat Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At home, farm building, etc. (Specify)		28f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	ledical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, (Check only one)  1 Medical Examiner: On the basis of examination and and manner stated.				
	To the within 2 To the complete	Me	29b. Signature and title of certifier	29c. License number		I. Date signed (Mont	
D	[7]		30. Name and address of person who completed cause of death (Item 23a) (T	M. D.   0101240316 (V ype, Print) NATIONAL		DICAL CEN	
<i>F</i>			STEVEN P. ARMBRUSTER LT MC USN  31. Date filed (Month, Day, Year) 32. Registrar's Signature		MD 20889		······
67	Sta Registr		FEB 0 7 2008 Steen M. Appell	,			

Arthur James West

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 0496

		- For State Registrar		Cer	tificate of	Death			F	Reg. No		
Physicia	_	Decedent's Name (First, Mide	dle,Last)					. 2	. Date of Dea Month	ath Day Yea		. Time of Death
ી Examin	er	Arth	ur <u>James</u>	West	IV				February	3, 2008		0925 hrs
		4a. Facility Name (if not instituti			4	b. City, Town,	or Location	of Death		4c. County o		
		Prince Georges Med	ical Center			Cheverly				Prince G		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Y			8. Date of B	irth(MM/DD/YYYY	9. Birthp Foreign	
Director		578-06-1739	1 XM 2 F		25 Yrs.		ays Hour	s Min.	04_0	1~1982	Coun	
	_ L	Usual Residence of Decedent			23	<u> </u>			04-0	71-1902		
any	-	10a. State 10b. County	у	10c. City,	Town or Locati	on					1	0d. Inside City Limits
<u> </u>		MD Prin	ce Georg	es D	istric	t Hoid	rh+c					1 X Yes 2 No
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n with mis 2	Funeral	11. Marital Status	A and 17	cedent Ever in U. orces?	S. 13. Wa	s Decedent of es, specify Cu	Hispanic Or ban, Mexica	igin? ( Spe n. Puerto R	cify Yes or N tican, etc.)		e - America e, etc.	ın Indian, Black,
or ite	ا جَ.		1X Yes	2 No					·			
after al",	畜	3 Widowed 4 D	ivorced If Yes, Give Yes or Dates:	ეე2−04		Yes 2 X				Specify:		lack
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S-0	3	17. Father's Name (First, Middl	e, Last)				18.Mothe	er's Name (	First, Middle	, Maiden Surname	*)	
121 Id be fil Mental H narked event, d	a	Arthur Jam	es West	III			Ma	raie	Dove	Flovd		
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ages I and 2 shount of Health and Int. If item 27 is not other traumatic		20a. Method of Disposition			Place of Dispos crematory or otl	ition (Name of	cemetery,		Date	20c. Location	- City or T	own, State
D I OF		1 X Burial 2 Cremati		OIII State	-		Dawle	02/	ng / 20	de tand	3 O T T O	r MD
ti. Pa	١,	4 Donation 5 Other 21. Signature of Funeral Service		по						d8 Land		L, MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene. Informati: If item 27 is marked other than "injury or other traumatic event, the Medical Is	Ų	//	. Willen							1 Servi		
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∡xaminer		Immediate Cause (Final disease										
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Box 687 c death certifi the attending ed for use as t	sici	1 Yes 2 No 9 U	tertura varia	nant at time of de	eath 5 O	ther (Specify)				4		
the de	چ	Part II. Other significant cond	9 Ulki		equiting in the	undorlying cou	co given in	Part I	23e Did	I tobacco use cont	ribute to t	ne cause of death?
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of V ing Phys After thi	의	1 ✓ Yes 2 No 27. Manner of Death	28a. Date	e of Injury	28b. Time of	Injury 28c.	Injury at Wo			e how injury occur		
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Sior Attend r death ector: by the	g		vestigation	ce of Injury - At h	ome farm, stre	et, factory, off	ice building.	etc.	28f. Location	(Street and Numl	ber or Rur	al Route Number, City
Nor after Dir	퉨		ould not be						or Town			
Divis	3	4 Homicide	(Op com)	Major Roa								
7 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	g	(Check only 1 Certifying one) 2 Medical Ex	Physician: To the be xaminer: On the basis	est of my knowled of examination a	ige, death occu and/or investica	rrea at the tim ition, in my oni	e, date and i nion, death	piace, and o occurred at	uue to the ca t the time, da	te and place, and	er as state due to the	cause(s)
To the I within 2	Medical	- 10,3	and manner	stated.			cense numb			29d. Date sig		
	Σ	29b. Signature and title of certi	itier					CI .			· .	· ·
(6)		Doma in	Julea Hi	(19)		0	.C.M.E.			February	<del>-,</del> ,∠∪∪8	
1011				-								
W/		30. Name and address of pers										
JU T		30. Name and address of personna M. Vincenti, I	MD Assistant		miner 11	1 Penn Str	eet, Baltir	more, Mi	D 21201			

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dorothy T. Williams 8:30 Рм February 2008 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Genesis Eldercare Spa Creek Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)

March 17, 1920 Pennsylvania 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 197**–**16–6789 1 □ M 2/CXF 87 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10b. County Maryland Anne Arundel Annapolis 1 ☐ Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2007 Chesapeake Road 21409 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Housekeeping 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Barbara Leisner George Seiger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jean Williams/daughter 2007 Chesapeake Road Annapolis, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Baltimore Crematory 2/4/2008 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. diate Cause /Final DEMENTI Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) in the past 12 mon 1 ☐ Yes 2 K No

**Physician** /Medical **Examiner** 

burial-tran

the. as

funeral director,

To the Hospital or Attending Physisithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director.

attending physician

requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

Be

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**Funeral** 

Director

72 hours after death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menal Hygiene. Important: If tiem 27 is and Menal Hygiene. Important: If tiem 27 is anxied other than "natural!" or thems 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician/Medical þ Be Completed Certification: To

disease or condition resulting in death)	a
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	<b>J</b> b.—
Cause (Disease or injury that initiated events resulting in death) Last	c
	d
IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If y

23	ac. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death
	9☐Unknown

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)
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-	23d. Date of de	elivery	
1	Month	Day	Yea
1			

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e.	Did tobacc	o us	e cor	tribute to t	use of death?		
	1 ☐ Yes	2	] No	3 ☐ Prob	oably	Unknov	
24a.	Was an autopsy		24b.	Were auto	psy fi	ndings availab	

	25. Was case referred to medical examiner?  1 Yes 2500
ı	27 Manner of Death

	Ho	spital: 1 🔲 Inpatie	ent	2 🗆	ER/Ou
nding estigation		28a. Date of Inju (Month, Da	ıry ıy Ye	ar)	28b. 7
uld not be	e	on- Diseasefiel		A A In	6-

patient	3 🗆 🛭	OOA	Othe
ime of njury		28c.	Injur Worl

prior to completion of cause of death? 1 □ Yes 2 □ No

Natural 2 Accident 5 Per 6 Could not be determined 3 ☐ Suicide 4 Homicide

	28a.	Date of Injury (Month, Day Year)
1		
9	200	Place of injuny. At he

28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes	2 □ No	
ome farm stree	t. facto	ory office		_

Nursing I	lome	5 🗆 Residence	6 ☐Other (Specify)
t	28d.	Describe how inj	ury occurred
s 2∐No			

6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	cian: To the best of my knowledge, death occurred at the time, date and placer: On the basis of examination and/or investigation, in my opinion, death occ	

26. Place of Death (Che

	one)			
9b.	Signature and	title	of	cerl

29a. Certifier

(Check only

29c. License number D39037

29d. Date signed (Month, Day, Year) 02 FEB 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

5 MITCHELL 31. Date filed (Month, Day, Year FEB 0 Day, Year)

2001 MEIGH PARKEDAY NEULIOUS M)

egistrar's Signature

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Frank Wright 28, 2008 2:00 P January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1305 Iverson Street #203 Oxon Hill

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Prince George's 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months 1 **X**M 2 □ F 579-64-9801 Director 56 31, 1951 Washington, DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 Is merked other than "natural", or Items 23a or 28a-f show 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1√ Yes 2 No Directo Maryland Prince George's Oxon Hill 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1305 Iverson Street #203 20745 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Never Married 2 Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ll years Maintenance Engineer Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Wright Mary Salmon 2 and N 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1305 Iverson St. #203 Oxon Hill, MD 20745 Sarah L. Wright 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of I Important: If ite any Injury or ot 1 → Burial 2 □ Cremation 3 □ Removal from State Washington Nat'l Cemt, Feb. 2, 2008 Suitland, MD Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service License 4001 Benning Road, NE Washington, DC 20019 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Liver Hepatoma **Physician** /Medical Due to (or as a consequence of): Examiner Liver Cirrhosis Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien end for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) I□Yes 2□No 9□Unknown 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were eutopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1☐ Yes 2 XNo Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 x Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐XNo 1 Inpatient 2 ER/Outpatient 3 DOA ပု After this 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig -31-2008 D0046046 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11711 Livingston Rd., Ft. Washington, MD 20744 Amir Alliahkhami, M.D. 32. Registrar's Signature State FEB 04 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend I tem II per wife, 18 per inf 878 4-16-08 vt. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav W0005 Month 2 (10) AM 08 OCK **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Odent.on 772 Seneca Dr. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 27, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 M 2 □ F **Funeral** 1923 Arkansas Feb. 84 429-34-9770 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Odenton MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21113 772 Seneca Dr. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Thever Married 2 Married filed within 72 hours after 1 ☐ Yes 2 ☒ No Specify: Black Specify Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced "natural", 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) event, the Medical College (1-4or 5+) Elementary/Secondary (0-12) other than Automotive Mechanic 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f <del>Orabell</del> Burgess permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic events. Dock Woods, Sr. is marked 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21113 Odenton, MD 772 Seneca Dr. Charles R. Woods / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/9/2008 Brentwood, MD 4 □ Donation 5 □ Other (Specify) Fort Lincoln Cem. 22. Name and Address of Facility 21. Signature of F eral Service Licenses Beall Funeral Home Bowie, MD 6512 NW Crain Hwy. 23a. Part1. Enter the disease, old implicitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed and-tran Due to (or as a consequence of): attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23d Date of delivery 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 3 Ectopic pregnancy Year 1 ☐ Live birth 2 ☐ Fetal death Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No ρ 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown the þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Menknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy has performe 26. Place of Death (Check only one) 25. Was case referred to medical <del>`∂ ∧</del> Be Other: 4 Nursing Home 5 Residence examiner? 6 Semer (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes ME 2 this 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After thi completely filled in his the formal presents. 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death filled in by the funeral Medical Certification: Iniury 1 Natural
2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Ian 10 Name and address of person who completed cause of death (Item 23a) (Type, Print) HIGHWAY ANNAPOLIS MOZIYOI 446 DEFENSE MEN A MM ICHARL 32. Registrar's Signatur Year) 31. Date filed (Month, Day, State 2008 FEB 05 Registrar

State of Maryland	/ Department of Health	and Mental	Hygiene

2008 0	) [	19	5	6
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David Winston V		Ot S 1- For State Registrar	tate o	f Maryla	•	artment of rtificate of			Ment	al Hyg	giene	Reg. N	No.	20	38	0496
Physicia Medical Exami	in/	1. Decedent's Name (First, Mide	dle,Last) 15 <b>t</b> or	ı Wi	1mot						Date of December 1 Dec	Death Da	ıv	Year		me of Death 600 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Bradley Boulevard and Brite Drive  Bethesda														
Funeral	-	5. Social Security Number	6. Sex		7. Age (In yrs. i	ast birthday)	If Under		If Under	24Hrs.	8. Date of	Birth/N				e (State or
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5-0036 fled within 72 Hygiene. I other than	Comple	17. Father's Name (First, Middle		<b>J</b>				18	8.Mother's	s Name (F	irst, Midd	le, Maio	ien Sur	name)		
1218 I be fill ental H irked	a	David W. Wil									Merc					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.	٢	19a. Informant's Name/Relation David W. Will			er	19b. Mailin	g Address Kalm									Code)
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Box 68760 ne death certificate the attending phys	an/Me	IF FEMALE: 23b. Was decedent pregnant in	the	23c. If yes, o	outcome of preg irth		etal death	3	Ectopic	pregnano	CV			ate of deli-	very Day	Year
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Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should the control of the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director.	-1	27. Manner of Death		28a. Date (Month, Feb 2, 2	of Injury Day,Year)	28b. Time of	Injury 2	Bc. Injury	y at Work		8d. Descr			occurred ject colli	ision	
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State Registrar ara

FEB 05

31. Date filed (Month, Day, Year)

2008

NO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T. Muscarich

Deferse they Gambrills, MD

MD

7:20рт м

**Physician** /Medical Examiner

Yolanda

Walton

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If ten 27 Is marked other than "natural" or iteme 222 any injury or other trainmair.

**Physician** /Medical Examiner

and as the burial-tra attending physician for use as the buria certificate

To the Hospital or Attending Physician: The law requires that the death certificate be executed Director: After this in by the funeral di within 24 hours a

To the Funeral [

Division or Vital Records, P.O. Box 68760,

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Villa Rosa Nursing Home Mitchellville Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6 Sex 8. Date of Birth (Month, Day, Year) NOV • 28, 1925 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F 578-22-0447 Director 82 Washington DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Prince George's Director Bowie 1 ☐ Yes 2 XNo 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 3437 Everette Drive 20716 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Secretary 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Primiano G. Williams Anna Scirraffa ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert A. Walton/son 2094 Montpelier Court, Crofton MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State MD. Vet. Cemetery 5 ☐ Other (Specify) 4 Donation Cheltenham, MD 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie MD 20715 23a. Part1. Enter the disease, or complicate shock, or heart failure. List only the complete Insthat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Canci Heri ne Due to (or as a consequence of) Dement Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 No 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) a □ Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: 2 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 □ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

2008

FEB 05

Rakesh Arora MD 14300 Gallant Fox Lane Bowie MD 20715

Amended #23a(a), nls, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. per phy., 02/12/08, State of Maryland / Department of Health and Mental Hygiene Allegany Co. 1 - For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day, 2008 **Physician** February [ Joseph Lee Welch, Sr 7:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Living Center Golden Cumberland Allegany 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Days Months Hours 1 X M 2 □ F Vrs Director 216-22-5815 07/05/1930 Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ns 23a or 28a-f shov must be notified at Director Mineral Ridgeley 1 to Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26767 items 23a 17 Blocker Street USA by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, s 1 and 2 should be filed within 72 hours after do if Health and Mental Hygiene. Ifem 27 Is marked other than "natural", or item other traumatic event, the Medical Examiner: Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Laborer Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Welch Dora Elizabeth Bailey ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph R. Welch / Grandson 182 Oak Drive Addition, Spencer, WV 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 02/03/2008 Cumberland, MD 21. Si, na ure of Funeral Service Licer 22. Name and Address of Facility Adams Family Funeral Home, F.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. Chronic pstructive Pulmonary Disease Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) JUVS /Medical Due to (or as a consequence of): Examiner eveloro Vasc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed pertension and burial-tran Die to (cras a consequence of) Records, P.O. Box 68760 attending physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy jo in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ţ a∏iJnknown 9 Unknown NIA ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 💢 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an has autopsy perform certificate or Vital 2 Nt or Attending Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Aursing Home 5 Residence 6 Other (Specify) 2 No ို 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After 1 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation Injury death. 1 □ Yes 2 □ No d in by the 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grantsville 2 Cov povate
32 Registrar's Lignature MRA

State

Registrar

31. Date filed (Month, Day, Year)

B 0 4 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State o	f Marylar		artment of H <i>rtificate of L</i>			giene 2	08	04970
	Di-	^	1. Decedent's Name	(First, Middle, La	ast)					2. Date of Dea	ath		3. Time of Death
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	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Funeral	11. Marital Status			edent Ever in U	.S. 13.	Was Decedent of Hi If Yes, specify Cuba		Decify Yes or No-	14. Race		can Indian,
36	s after ; or it	by Fu	1 ☐ Never Married 3 ☐ Widowed 4		1 ∑ Yes If Yes, Gi	<sup>2</sup> □No 19	<del>1</del> 3-	1 ☐ Yes 2 ☑ No	Specify:	o i noun, oto.)	Specify:	k, White,	etc.
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ryla	should be and Mental s marked or umatic eve	မ	Otis 19a. Informant's Nam	ne/Relationship	(Time Print)	Wall		ng Address (Street a	Ethel	ral Davida Alverta	Hewi		0-4-1
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Division or Vital Records,	lor Al after o Direc	Certification:	4 ☐ Homicide	determined	28e. Place buildi	of Injury - At ho ng, etc. (Specif	ome, farm, sti y)	eet, factory, office		28f. Location (S: City or Town	treet and Numbe n, State)	r or Run	al Route Number,
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	he Ho in 24 t he Fu pletel	edical	(Check only 2 one)	☐ Medical Exa	miner: On the b	asis of examina ner stated	tion and/or in	vestigation, in my or	inion, death occur	rred at the time, o	date and place, a	nd due t	o the cause(s)
	Within Com	Σ	29b. Signature and tit	le of certifier	1.1.			29c. License		2	9d. Date signed		•
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	C,x,		30. Name and addres	s of person who Poonai				Print) rive, Cuml	perland.	MD 215	02		
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DHMH 17 Rev 1/2001

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			1- For State of Maryland / Dep. Registrar Ce	artment of Health ar rtificate of Death	nd Mental Hy	giene 2008	04971
Ŋ,			1 Decedent's Name (First, Middle, Last)		2. Date of De	eath	3. Time of Death
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п	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2X F	If Under 1 Year If Under 24  Months Days Hours	Hrs. 8. Date of Bi	rth 9. Bir	rthplace (State or Foreign
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	Mary f sho	ō		ge Park			1 □Yes 2 No
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	be filed within 72 hours after death with the Maryland Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral		Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F			
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Baltimore,	it. Part rtant rtant njury		4 ☐Donation 5 ☐ Other (Specify) Menorah			Rockville,	
g	permit. Pages 1 and 2 should be Department of Heatilt and Menta Important: If item 27 is marked any Injury or other traumatic en			2. Name and Address of Facility			
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent	1800 New Hampsh		-	Approximate
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	Physician /Medical		disease or condition Advanced Alznell	mer's Disease			
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5	the death certifi y the attending p ched for use as	/sic	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)		Month	Day Year
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5	<b>Physician:</b> The law t this certificate has t ral director, page 2 s	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	Other:	Death (Check only of		
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	ospit hours unera ly fille		29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death	occurred at the time, date and p	place, and due to the	cause(s) and manner as	s stated.
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	Vithi Com	ž	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mont	th, Day, Year)
	12		hovem whuman	D59524		February	1, 2008
	ı		30. Name and address of person who completed cause of death (Item 23a) (Type, I	Print)			
			Loveen J. Puthumana, 3110 Gracefield		pring, MD	20904	
	Stat		31. Date filed (Month, Day, Year) FEB 0 4 2008 32. egistrar's Signature	auti)			
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DHMH 17 Rev 1/2001

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1- State of Maryland / Department of Health and Mental Hygiene 2008

Hertificate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 11:05 P M Pau1 G. Warner January /Medical 28, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Numbe **6869** 185–12–8689 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 □ F 89 Yrs Director March 21,1918 Pennsylvania Usual Residence of Decedent a or 28a-f show the notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 No D.C. none Washington, D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 5514 Carolina Place, N.W. 20016-2528 U.S.A. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien. Important: If item 27 is marked other the any injury or other traumatic event, the 1 once. U.S.I.A. News Editor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawrence Warner 2 Nellie Scanlon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5514 Carolina Place. N.W. Washington, D.C. 20016—2528 Paul T. Warner/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Feb. 2, 1 X Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) St. Joseph Cemetery 2008 N.Versailles, PA 22. Name and Address of Facility DeVol Funeral Home 21. Signature Hour ral Se vice Livens KUEE 2222 Wisconsin Ave., N.W. Wash., DC 20007 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LARYNGEAL Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical the attending phase as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2□ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 phopatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No After this 27. Manger of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural (Month, Day Year) 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) es, MD 00057124 211108 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Medical Center Drive Rockville, MD 20850 Truong Bao, MD 31. Date filed (Month, Day, Year) 32, egistrar's Signature State FEB 04 2008 Registrar

Hecords, P.O. Box 68/60,	Baltimore, Maryland 21215-0036	121215-0036
he law requires that the death certificate be executed	permit. Pages 1 and 2 should be filed within 72 hours after d	lled within 72 hours after d
has been signed by the attending physician and	Department of negating and mental hygiene.	Tyglene. her than "natural", or Item
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3	Funeral Director		5. Social Security Number 6. S	M 2□F		last birthday) Yrs.	Months Da			8. Date of Bi (Month, Da	ay, Year		Coui		=
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	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13.1	Was Decedent of Yes, specify C		Origin? (Spe	cify Yes or No		14. Race	e - Americ	can Indian,	
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21215-0036	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dieal Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E	Year or Dates:			dent's Usual Oc				16h l	Kind of Bu			
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	ges 1 and 2 should be filed within 72 hours after di tt of Health and Mental Hyglene. If Item 27 is marked other than "natural", or Item or other traumatic event, the Medical Examiner.		SOON H. WILSON -	WIFE			AUTUMN								
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8			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	the death	h. Do not ent	er the mode of	dying, such a	as cardiac o	r respiratory a	arrest,			Approximate Interval Betw Onset and D	een
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	To the Hospital or Attending Physician: The law Within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certification:	29a. Certifier  (Check only one)  1 Certifying Pl 2 Medical Example 1	nysician: To the best miner: On the basis o and manner sta	examina	wledge, deat ition and/or in	h occurred at th vestigation, in r	e time, date a ny opinion, d	and place, and place, and place, and place and place and place and place and place and place and place, and pl	and due to the ed at the time	e cause( e, date a	s) and ma nd place,	anner as a	stated. to the cause(s)	
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	Sta	te.	31. Date filed (Month, Day, Year)	CHENG A		4 4 0 1 ature	Medic	cal le	nter	Drive	, 1	COCK	ville	MD	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🗎 🗎 🥄 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Howard H. Williams, Jr. 1/31/2008 9:56 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Adventist Hospital Montgomery Takoma Park Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth (Month, Day, Year) 1⊠M 2□F Director 228-22-7598 82 Yrs. 3/26/1925 Virginia Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ehow the Medical Example of misst be notified at Director 1 ves 2 No Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1817 Long Fellow St. 20782 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 natural, or 1 ☐ Yes 2 No þ Specify: **Black** 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry s 1 and 2 should be filed within; f Health and Mental Hygiene. Item 27 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 10 Cable Supervisor AT & T 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Howard H. Williams, Sr. Dorothy Louise Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tilithia J. Williams, Daughter 2905 Queens Chapel Rd., # 2, Mt. Rainier MD 20712 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H important: If ite any injury or oti 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 2/8/2008 Brentwood, MD 21. Signature of Funeral Service Licen-22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death THEUNIONING **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and s the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Year Month 4☐Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? TELDE OLITIS CONTHELOSTUDINE VOS certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No ို 1 Unpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No I Director: A d in by the fi 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)



			1 - State Registrar	ate of M	aryland		artment of rtificate o			ental Hygi <sub>Re</sub>	ene g. No. 20	08	04	975
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3	Funeral Director		5. Social Security Number 6. Sex 1 M		ge (In yrs. las 84	t birthday) Yrs.	If Under 1 Yea Months Day		24 Hrs. Min.	8. Date of Birth (Month, Day, June 2	Year)	9. Birthp	place (State o	r Foreign
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	with the N 3a or 28a- 1 be notifi	Funeral Director	10e. Street and Number 13436 Maugansville				10f. Zip Code 2174			10	g. Citizen of W			
036	be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 12. V 1 Married 2 Married 1	Vas Decedent Irmed Forces? Yes 2 X Yes, Give ear or Dates:		1	Vas Decedent of Yes, specify Co	f Hispanic Ori uban, Mexicar		cify Yes or No- lican, etc.)	14. Race	e - Americ k, White,	an Indian, etc.	
21215-0036	d within 72 ho giene. r than "natur the Medical I	Completed	15. Decedent's Educatio (Specify only highest grade con Elementary/Secondary (0-12)	n npleted) College (1-4or (		(Give life. [	ent's Usual Occ kind of work dor DO NOT use reti nestic/L	e during mos red)		g	6b. Kind of Bu		dustry	
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Baitimore,	permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 is marked any injury or other traumatic e one.		20a. Method of Disposition  1 ☑ Burial 2 □ Cremation 3 □ Remode 4 □ Donation 5 □ Other (Specify)	val from State	Reif	etery, cren f Men ch Cer	sition (Name of natory or other p nonite netery		2/9/0	08 0	earfos	s, M		
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	the Hosp in 24 hou the Funer ipletely fill	Medical	29a. Certifier (Check only one)  1 ☑ Certifying Physician 2 ☐ Medical Examiner: (a	: To the best on the basis of the basis of manner sta	f examinatior	dge, death and/or inv	occurred at the estigation, in my	time, date an opinion, dea	nd place, ar ath occurred	nd due to the cau d at the time, dat	ise(s) and mar e and place, a	nner as st ind due to	tated. the cause(s	)
	To Ten	Σ	29b. Signature and the of certifier	1 mos	2	MI		632	33	290	Date signed		Day, Year)	3
	7		30. Name and address of person who comple' SHAHID MAHMOO 5	ted cause of de	eath (Item 23	a) (Type, F	VE. HA	GERST	TOWN	MD.	2174			
	30. Name and address of person who completed cause of death (ifem 23a) (Type, Print)  SHAHID MAHMOOD SEO NORTHERN AVE. HAGERSTOWN, MD. 21742  State Registrar  FFR 1 6 2008  Registrar's Signature  FFR 1 6 2008													

08-01142	
John Edward	Young

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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		uneral irector		5. Social Security Number 6. Sex 7. As 1 X M 2 F	ge (In yrs. last birthda		Year If Under 24Hr Days Hours Mi		/1949 G. Bi	rthplace (State or gn Maryland buntry)
		any		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	_ocation			1 10 2 1 2	10d. Inside City Limits
	P		<u>_</u> 1	Maryland Charles		Wa	ldorf			1 X Yes 2 No
3	Aarvla	28a-F	Director	10e. Street and Number	<u> </u>	10f. Zip Coo		10	g. Citizen of What Cou	intry?
	h the	3a or otifie	ı Dir	3237 Ryon Court		206			USA	
091	hours after death with the Maryland	or items 23a or 28a-f show must be notified at once.	Funeral	11. Marital Status  1 Never Married 2 Married 12. Was Deceden Armed Forces 1 X Yes 2			Hispanic Origin? ( S ban, Mexican, Puert		14. Race - Amer White, etc.	rican Indian, Black,
	safter	ral", c	by	or Dates	71-72		No specify:		Specify: B1	
			Completed	15. Decedent's Education (Specify only highest grade co Elementary/Secondary (0-12) College (1-4 or	duri		upation (Give kind of life. DO NOT use re		16b. Kind of Business.	/Industry
	5-0036 led within 72	ne. r than Iedica	nple	12		illed La	aborer		Amisco	
	21215-0036 uld be filed within 7	Hygie d othe		17. Father's Name (First, Middle, Last)			18.Mother's Nam	e (First, Middle, M		
	2121	Mental marke event	To Be	James M  19a. Informant's Name/Relationship (Type, Print )	Your		Helen	Rural Route Numi	M ber, City or Town, Stat	Brown
	MD d	h and 27 is 1 imatic	-	Tawanda Young/Daughten	- 1				aryland 2	
	re,	Department of Health and Mental Hy Important: If item 27 is marked of injury or other traumatic event, th		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from S	20b. Place of D	isposition (Name or other place)		Date	20c. Location - City o	
	Baltimore, permit. Pages 1 ar	nent o lant: ] or oth		4 Donation 5 Other Specify:	Maryla	nd Vete	rans 2/	26/08	Cheltenh	am,Marylan
	Balt permit.	Depart Impori njury		21. Signature of Funeral Service Licensee	101	22. Name and Add	ress of Facility Ad	ams Fun	eral Hom	e PA
		sician		29a. Part I. Enter the disease, or complications that caused	191 i	ter the mode of dy	quasco King, such as cardiac	or respiratory arre	st, shock, or heart	yland20608 Approximate Interval
	/M	edical iminer		failure. List only one cause on each line.  Immediate Cause (Final disease a.	ine Intoxica	tion				Between Onset and Death
	Ad			or condition resulting in death)  Due to (or as a cons	sequence of):					
			er	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a constitution)	sequence of):					<del>                                     </del>
			Examine	cause. Enter Underlying Cause (Disease or in jury that in Itlated events resulting in death). Last  Due to (or as a cons	compance of):					4
	cuted	nd Iransit		events resulting in death) Last Due to (or as a cons						
	), be exe	the attending physician and ed for use as the burial - transit	Medical	X UNPENDED AMENDED # 2	3a.27.28a—f	ner MEO G	-880 6/16/08	reh		
	376C	g phys s the bi		IF FEMALE: 23c. If yes, outco	,		3 Ectopic pregr		23d. Date of delive Month	ry Day Year
	X 68	ttendin r use a	iciai	past 12 months?	t time of death 5	Fetal death Other (Specify)	5Ectopic pregi	iancy	Month	Day Teal
	. Bo	y the a	Physician/	1 Yes 2 No 9 Unknown g Unknown  Part II. Other significant conditions contributing to dea	th but not reculting in	the underlying ear	so given in Bort I	23e Did to	bacco use contribute to	the cause of death?
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	ecol he law	ite has ige 2 sl	dmc					autops perform	med? death?	completion of cause of es 2 No
	<u>a</u>	his certificate l director, page	انه	25. Was case referred to medical		26.P	lace of Death (Checi			
	Viysici	r this c al dire	To B	TV Tes 2 INO	ent 2 ER/Outpa				Residence 6 🗸 Othe	er: Scene
	n of	h. After ti funeral	1	27. Manner of Death  1 Natural 5 Pending  28a. Date of Inj (Month, Day)	Year)	1	Injury at Work? Yes 2 X No		ow injury occurred	
	Sio	rector by the	icati	2 Accident Investigation Pho. 2/9/	08 Fnd.	3:34an		Unknown 28f. Location (S	itreet and Number or R	ural Route Number, City
		urs after	Certification	Suicide Could not be	Residence [ 1	•	3.	or Town, St		
	Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of n	ny knowledge, death o	occurred at the time	e, date and place, an	d due to the cause	e(s) and manner as sta	ited.
	To th	To the	Medical	one) 2 Medical Examiner: On the basis of examiner stated 29b. Signature and title of certifier	mination and/or inve		ense number	at the time, date a	and place, and due to t	
-				200. Signature and the or certified			C.M.E.		February 9, 200	
				30. Name and address of person who completed cause of	death (Item 23a)					
ĺ	bB			David Fowler M.D. Chief Medical Exam	niner 111 Pen	n Street, Baltii	more, MD 2120	1		,
		Si Regis		31. Date filed (Month, Day, Year)	ar's Signature	Sparte				

OCME

Registrar

FEB 0 5 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Year Ann 15,2008 Holams ebruary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 0 Hospital Baltimore Sinai Baltimore N If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 6. Sex **Funeral** Year) 1□ M 2 F 216-76-Adaws - Win bus Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1√Yes 2 No MD. Itimore Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or with ondawmin USA 3031 21216 by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Examiner 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Black Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) the Medical E Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) are tlaerly 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ationt Known Wimbush ဥ 19a. Informant's Name/Relationship (Type. Print) [-] 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. Balto, MD. ZIZI6 Mondawmin 3031 eginald <del>Adams</del> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 02-22-08 orraine Cemetery Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Vaughn C. 5151 Balto. Funeral Services Vatil Pike Bulto MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** oronu /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Cardio My Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl for use as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 □ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an was a autopsy performed? or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[ No 1 Inpatient Certification: To 1 Tyes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? after death. 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D63298 s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and adore 31. Date filed (Month, Day, Year)
FFR 2 0 2008 State FEB 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 1- State Registrar Amend #1, perMD,fg876, 2/20/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** Month Dav 13:45 M Tola Odessa Adams FCL 132008 Adams /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore University Mayland Medical Center ot Social Security Number If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Days Months 6-28.9568 1 M 2 F Director 02-23-28 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at MD 1 ZYes 2 No Baltimore Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number tve 208 60 USA Ivania 21201 Completed by Funeral Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No ō Baltimore, Maryland 21215-0036 Specify 3 Widowed 4 □ Divorced lack Year or Dates "natural" other than "natu 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Weltord Kobinson ပ Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, BOLTO MP Health a 3606 herm ohnson Daugnter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ☑Burial 2 ☐Cremation 3 ☐Removal from State Windsor Mill, MD. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 21229 Baltimare 515Y 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of) artery discase 10 years /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician a Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknow signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼No 24a. Was an autopsy performed? Yes 2 No 2 No To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 100 Natural Injury 1 □ Yes 2 □ No 2 Accident within 24 hours after death To the Funeral Director: Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical сотретел 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18151 Teb. 15 2008

Registrar
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32. Registrar's Signature

Greene Street, Belpinore, MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760,

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To the Hospital or Attending Physician: after death. filled in by

29a. Certifier

29b. Signature and title of certifier

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and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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Baltimore

29d. Date signed (Month, Day, Year)

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Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

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Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) BLAIR **Physician** Month Dav HNDREW February 2008 /Medical 4a. Facility Name (If not institution, give street and number) . City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hospita If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 5ex 1.2XM 2.□F Hours Days 06/24/1958 Maryland Director 219-74-0048 49 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Ex∍mIner must be notified at 10d. Inside City Limits Glen Burnie 1 TYes 2 XNo MD Anne Arundel 10f. Zip Code 21061 10e. Street and Number 10g. Citizen of What Country? with t 7786 Hancock Lane, Apt. A United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or White 1 ☐ Yes 2 No Specify. ģ Specify: 3 ☐ Widowed 4 X Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Transportation Manager other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Oscar E. Blair Adelia Gregory ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7786 Hancock Lane, Apt. A, Glen Burnie, MD 21061 19a. Informant's Name/Relationship (Type. Print) Andrew G. Blair, Jr. Son if Health a 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/19/2008 Medcure, Inc. Portland, Oregon 4 Donation 5 DQther (Specify) Harman Funeral Service, PA 21. Signatu Fun r Service Licensee M01113 22. Name and Address of Facility 7221 Grayburn Drive, Glen Burnie, MD 21061 U 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine ing physician and the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day Month Year 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a detached for ☐Yes 2☐No 9□Unknown 9 Unknown The law requires that signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼ No 24a. Was an has autopsy performed? res 2 No 1☐ Yes Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After Certification: 5 ☐ Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide determined 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature, and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1000 N. WOLFF 32. Registrar's Signature

Street Baltimore

FRANI

134T

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician FEBRUARY 17, /Medical WILLIAM T. 5:00 P BARRETT 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FUTURECARE CHESAPEAKE ARNOLD er 1 Year | If Under 24 Hrs. ANNE ARUNDEL If Under 1 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 □ F Hours 70 Director VIRGINIA 224-44-5941 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2√√No Director MARYLAND ANNE ARUNDEL LINTHICUM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral filed within 72 hours after death 727 HELEN AVE. UNITED STATES

14. Race - American Indian, <u> 21090</u> 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Year or Dates: 162-166 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 3 Midowed 4 Divorced natural al Hygiene. I other than "naturs vent, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PLUMBER HOME IMPROVEMENT permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any lipiny or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM T. BARRETT MADELINE VIRGINIA BARNES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANK WIRTZ / FRIEND 20 CHESTNUT HILL AVE., SEVERNA PARK, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State FEB. 21, FORREST LAWN CEM. 4 Donation -5 ☐ Other (Specify) NORFOLK, VIRGINIA 2008 Tuneral W rvice Li 🖟 nsee 21. Sign ture 22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME ; AMD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 1119 cancer y Qar /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760; Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) this certificate has been signed by the a al director, page 2 should be detached f 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 2 □ No 3 Probably 4 Unknown Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 27 No in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation М 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide completely filled \*\*Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) and address of person who completed cause ordeath (Item 23a) (Type, Print) and B. Berez MD 2225 E Defense Hwy, Crofton, MD 21114

DHMH 17 Rev 1/2001

State Registrar 32. Registrate Signa

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-04985 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician Month BROWN OS:16 AM EDWary 200\$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltrune Baltimore City 5. Social Security Number If Under 1 Year | If Under 24 Hrs. . Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) January 9 1922 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 → M 2 □ F 212 18 0877 86 Baltimore, Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Mary.land Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 Funeral 7136 Greenwood Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. MXYes 2 □ No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2XX Married 1 ☐ Yes 2K No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Crane Operator Ellicott Machine Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Snyder Brown Barbara Anna Parr ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard W Brown Jr 4312 Jefferson Avenue Sykesville, Md. 21784 (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem. Park February 18 2008 4 Donation 5 Dother (Specify) Glen Burnie, Maryland 22. Name and Address of Facility Lassahn Funeral Home, Inc 21. 50% tury of Funeral Service Lio need 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** meseutenc 1 day Due to (or as a consequence of): aortic aueurysm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death Day 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy pertormed 1∐ Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

r than "natural", or items the Medical Examiner mu

It of Health and Mental Hygiene.
If item 27 is marked other than
or other traumatic event, the Me

/Medical

Examiner

burial-transit

physician the

attending properties for use as

Pages 1 Department of Important: If it any injury or or

28a-f show ms 23a or 28a-f sf must be notified

funeral director, this After t within 24 hours after death

To the Funeral Director:
completely filled in by the Hospital or

State Registrar

29a. Certifier (Check only

29b. Signature and title of certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A A A HOLLAN MUD 30 L ST POWN ST

32. Registrar's Signature 31. Date filed (Month, Day, Year) 2 FEB 0 200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Margaret **Physician** Month 12:22 A M February 200g /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of De Examiner Baltimore Washington Medical Center Anne Arunde Cleu Burne 8. Date of Birth (Month, Day, Year) Feb. 1, 19 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🛛 F 86 578-32-8628 Director 1922 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show ns 23a or 28a-f shov must be notified at Director 1 □Yes 217 No Maryland Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must be n 209 Woodloch Lane United States Funeral 21146 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ Specify: 3 N Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Inspector 12 Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James A. Furman Beatrice E. Bly 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sue Ellen Jones / Daughter 209 Woodloch Lane, Severna Park, Maryland 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 24 20c. Location - City or Town, State Feb. 1 ☑ urial 2 ☐ Cremation 3 ☐ Removal from State Sweden Hill Cemetery 5 ☐ Other (Specify) 2008 4 🗆 I onation Coudersport, PA 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A.
421 Crain Hwy., S.E., Glen Burnie, MD 21061 21. Signa e of Fun val Servio License 0 23a. Part1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metabolic acidosis Physician resulting in death) /Medical Due to (or as a consequence of) **Examiner** sensis Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner the death certificate be executed Tract UYINAYY attending physician and for use as the burial-tran Due to (or as a consequence of) Bladder Concer IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? clustridium difficile 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,

or Attending Physician: completely filled in by the funeral director, after death Director: within 24 hours a To the Hospital

Registrar

29a, Certifier

29b. Signature and

Medical

State

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

eted cause of death (Item 23a) (Type, Print) JACOBS MY 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? [] [] § Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12<sup>Day</sup> **Physician** Feb. 20ď8 Joseph J. Babka, Jr. 8:20 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie
f Under 1 Year | f Under 24 Hrs. | 8. Date of Birth
fonths | Days | Hours | Min. | (Month Day, Year)
Aug. 6, 1928 North Arundel Health & Rehab. Anne Arundel 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1√2M 2□ F Months 79 Director 216-24-7860 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10h County 1 ☐ Yes 2 No Director Anne Arundel Glen Burnie Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 123 Fifth Ave., SW 21061 Funeral 12. Was Decedent Ever in U.S. Armed Forces? KOREAN 1 ⊠ Yes 2 □ No If Yes, Give WAR Year or Dates: 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 White 1 ☐ Yes ŽŒNo Specify: Specify: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Crane Operator MD Port Authority 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph J. Babka, Sr. Viola KROFCIK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, MD JoAnn E. Schemm / Daughter 109 Mall Road 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Nurial 2 □ Cremation 3 □ Removal from State Feb 15, 4 □ Donation 5 □ Other (Specify) \$1en Haven Mem. Pk. Glen Burnie, Maryland 21. Signature Funeral Service Licensee Kirkley-Ruddick Funeral Home, P.A. 0 421 Crain Hwy. S.E. Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one can be on each line. 0 Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (it as a donsequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 12XNatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29h. Signature and title of certifier February 13, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) alet A 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

FEB 2 0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month orman Februay /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Deat Hospital Baltmore If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 **≥** M 2 □ F Director 220.24.7547 08.16.1930 MD 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☐ No Director MD Glen Burnie A,A. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. items 23a 352 Constitution Ct. Funeral 21061 A . 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status r than "natural", or item the Medical Examiner Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: ✓ 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. 10 Painter Residential 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Braun Susan Keller ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai 7 Fdgeview Road, Towson, MD 21286

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or 1 Mildred L. Valis/Sister 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Fernation 3 ☐ Removal from State Chesapeake Crem. 02.20.08 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, PA M01442 8717 Green Pastures Drive, Balto., MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Defompensated /Medical Due to (or as a consequence of): Examiner Monic Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed eumonia to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by manumbor 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 autopsy performed 2 No 2 No Vita Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient Certification: To 2 ER/Outpatient 3□ DOA Division or 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 29a. Certifier 1 🗹 certifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) whan. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SILINAY VANAMINA. MD HAYDOY HOSPITAL 3001 S. HANOVEN SKEET, BALLMACLIZES 32 Agegistrar's Signat A Buss Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of Ma	ryland /		artment of H <i>tificate of L</i>			ental Hy	•	000	C	ntago	)
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k	Physici /Medic		Helen Baerhold							Februa	ry Da	<sup>y</sup> 9, 200	38	3:00 A M	!
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			Charlestown Care 5. Social Security Number 6. Se		(In yrs. last b	irthdayl	Catonsvi If Under 1 Year	111e	er 24 Hrs.	8. Date of Bi	I	Baltimo		(0)-1	_
l.	Funeral Director			M 2⊠F / Age	91	Yrs.	Months Days	Hours	s Min.	Jan.31	ay, Year,	)	Count	ace <i>(Stat</i> e or Foreigi ry) Land	7
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	the M 28a-f notifie	Director	Maryland Baltimor  10e. Street and Number	·e	Cato	onsv:	i11e 10f. Zip Code	_			10a Ci	tizen of What	Count		_
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2-0036	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	0		I □ Yes 2 1 No			iloan, etc.)		Black, W		ite	
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	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a		_	MSTI CCP	10	10100	DIE			-		_
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coras,	requir									12	Yes 2	□ No 3□	Proba	bly 4 □Unknown	
ב	Physician: The law requires that the death certif this certificate has been signed by the attending al director, page 2 should be detached for use a	Completed									psy ormed?	prior death	to com 1?	sy findings available pletion of cause of	
ווס	sian: ertifica ctor, p	BeC	25. Was case referred to medical examiner?					26. Pla	ce of Death	1□ Yes (Check only o	2 No one)	1 □ Y	es 2	!□ No	_
5	hysic this ce al dire	2	1 □ Yes 2 No	Hospital: 1 ☐ Inpatien				414	dursing Hom	e 5□Resi	dence	6 □Other (S	pecify)		
	ng I	tion:	27. Mariner of Death  1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day	Year) 28b.	Time of Injury	28c. Injury Work M 1 □ Y	rat :? /es 2[		3d. Describe	how inju	ry occurred			
2	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h. completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injur building, etc.		arm, stre				Bf. Location (			Rural	Route Number,	= 11
ב	spital or nours at meral D		29a. Certifier CertifyIng Physics	sician: To the best of	my knowledge	e, death	occurred at the tim	ne, date	and place, ar	nd due to the	cause(s	) and manner	as sta	ted.	112
	thin 24 the Fu	Medical	(Check only one) 2 Medical Exami	ner On the basis of a	examination ar	nd/or inv	estigation, in my op	oinion, d	eath occurre	d at the time,	date and	d place, and o	due to t	he cause(s)	
	17		Signature and title of certifier	, m	D		29c. License	74	47		Feh	te signed (Mo	9 , 7	OUS	
			30. Name and address of person who co	impleted cause of dea	ath (Item 23a)	Type, F	Choice	, (	9Ne	C	ate	NSIL	u	¥	
į	Star Registra		31. Date filed (Month, Day, Year)  FFR 2. (1 2008)	32. Registrar	's Signature	Ser.									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Joan Vivian Boteler FEBRUARY 14 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE WASHINGTON MEDICAL ( Ulen 8. Date of Birth (Month, Day, Year, 09/19/1932 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) Maryland **Funeral** 7. Age (In yrs. last birthday) Months 1 □ M 2 🖺 F Days 75 218 28 8937 Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits notified at 1 ☐ Yes 2 No Maryland Directo Anne Arundel Hanover 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 7853 Old Telegraph Road injury or other traumatic event, the Medical Examiner must be 21076 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify. Specify: White þ 3 Nidowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12th Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Edward Welsh Amelia King 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)2106019a. Informant's Name/Relationship (Type. Print) Brenda Lee Boteler / Daughter 308 Blue Border Court #101 Glen Burnie, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or o 1X Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 102/18/2008 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 Part1. Enter the disease shock, or heart failure. cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause) in each line. Immediate Cause (Final **Physician** FURUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ONIC OBSTRUCTIVE TUlmONAPY Gayes thatly first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the 9∏Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe page rmed? 2 No certificate 1□ Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2**□**∕No 1 Inpatient P 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural (Month, Day Year) Injury 5 Pending death. investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director... 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Medic 29b. Signature and title of certifier

Box 68760, P.0. Division or Vital Records,

State

31. Date filed (Month, Day, (ear) 2 0 2008 32. Registrar's Signatu

29c. License number 49

d cause of death (Item 23a) (Type, Print) 01

Registrar DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryla		artment of H			ienė 008	04991
2.50	Physic /Medi		Decedent's Name (First, Middle, Las	GILBERT EA	RL BRO	OWN		2. Date of Death Month FEB . 1	Day Yea	3. Time of Death
	Examir		4a. Facility Name (If not institution, give  COPPER RIDGE  5. Social Security Number 6. Se		s. last birthday)	SYKES\	If Under 24 Hrs.	8. Date of Birth	4c. County of De CARROI	ath  L irthplace (State or Foreign
L	Director		Usual Residence of Decedent	M 2□F	84 Yrs.	Months Days	Hours Min.	(Month, Day, 2/11/1		RYLAND
	ath with the Marylan 23e or 28a-f show ust be notified at	tor	10a. State 10b. County  MD CARROLI		City, Town or Lo	cation STMINSTE	R			10d. Inside City Limits 1
	with the	I Director	10e. Street and Number 38 WEBSTER ST.		-	10f. Zip Code	7	10	g. Citizen of What (	Country?
36	72 hours after death with the Maryland "natural", or Items 23e or 28a-f show idical Examinat must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Amed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: ₩₩			spanic Origin? (Spec n, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc. HITE
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after des Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or Items any injury or other treumatic event, Item witcal Examiner in Once.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation	16a. Deced (Give life. I	tent's Usual Occupa kind of work done d DO NOT use retired,	luring most of working	g	6b. Kind of Busines	s/Industry
Maryland 2	ould be filed Mental Hyg erked other etic event, I	To Be C	17. Father's Name (First, Middle, Last)	BERT E. BRO	WN, SI		18. Mother's Name EVA MA	(First, Middle, M		
	nd 2 sho alth and 27 is m		19a. Informant's Name/Relationship (T) RALPH T. UEBERS				nd Number or Rural Т. S.Т. Ты			
Baltimore,	Pages 1 ament of Heatant: if itam		20a. Method of Disposition 1	Removal from State	Place of Dispo cemetery, cren CRGREEN	sition (Name of natory or other place N MEM • GA	P 2/19 / RDENS	08 F	oc. Location - City o	or Town, State  G, MD
Ball	Depart Depart Impor any in		21. Signatur al Sance Licens	96	22	Name and Addres	s of FacilityFLET	CHER F	UNERAL	HOME, P.A. MD 21157
	Pnysician /Medical		23a. Part 1. Exter the disease, or comp shock, or neart failure. List only o Immediate Cause (Final disease or condition resulting in death)	Den	ath. Do not enti	er the mode of dying	, such as cardiac or	respiratory arres	st,	Approximate Interval Between Opset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or is a conse						
,8760,	icate be executed physician and the burial-transit	ai Examiner	that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
9		Medicai	IF FEMALE:	1						
.O. Box	The law requires that the death certif te has been signed by the attending page 2 should be detached for use a	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fel 4 □ Pregnant at time of 9 □ Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	əlivery Day Year
Records, P	w requires that been signed t should be det		Part II. Other significant conditions con	stributing to death but not re	sulting in the ur	derlying cause give	n in Part I.	23e. Did toba		to the cause of death? Probably 4 □Unknown
		e Completed	25 Was assaultaned to modical						ed? prior to death? Z No 1 Ye	tutopsy findings available completion of cause of s 2 No
Division of Vital	무 무 F	ToB	25. Was case referred to medical examiner?  1   Yes   2   No   1    27. Manner of Death  1   Natural   5   Pending	ospital: 1 Inpatient 2 2  28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	Oth -	at 28	-	ce 6 Other (Sp.	ESISTED .
Divisio	or Attan	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Spec	nome, farm, stre	M 1 🗆 Y	es 2 No	f. Location (Stre City or Town,	eet and Number or F State)	iural Route Number,
	a Hospital 24 hours a e Funarel l letely filled	edical C	29a. Certifier (Check only one)  1/2 Certifying Physical Examination (Check only one)	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the time estigation, in my opi	e, date and place, an nion, death occurred	d due to the cau at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the To the complet	Me	29b. Signature and title of certifier	MP		29c. License			d. Date signed (Mon	th, Day, Year)
			30. Name and address of person who co		m 23a) (Type, F	307 W	8137 Jestninsti	e u	10 21	157
	Sta Registr	6.	31. Date filed (Month, Day, Year) FEB 2 0 2008	32. Registrar's Sign	ature					

State of Maryland / Department of Health and Mental Hygien 🖁 🗓 🖯

1-	For State Registrer
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			- State Registrer			Cei	rtificat	e of l	Death			Reg. N	o.			
	*		1. Decedent's Name (First, Middle, La	st)							2. Date of D Month		ay	Vans	3. Time of Death	
	Physici /Medi		HELEN EL]	ZABETH P	OCIANO	WSKI							2008	Year	6:30 P	M
2	Examir		4a. Facility Name (If not institution, giv	e street and numb	er)		4b. City,	Town, or	Location	of Death		4	c. County	of Death		_
			QUAIL RUN NURSIN	IG HOME			F	PERRY	HAL	L			BALT	IMOR	Ε	
15	Funeral		Social Security Number 6. S		Age (In yrs. I	ast birthday)	If Under		If Under		8. Date of B	irth	.	9. Birthp	ace (State or Fore	gn
	Director		217-09-7390	□M 2X□F	89	Yrs.	Months	Days	Hours	Min.	DEC.	ау, Үөаг 27	1918	Coun	MARYLAN	
	2		Usual Residence of Decedent					1						_		
	yland now		10a. State 10b. County		10c. City	, Town or Lo	cation							1	Od. Inside City Limi	is
	Mar.	ţ	MD. BALTIN	ORE.	р	ERRY F	AT.T.								1 Yes 2 N	0
	28e	Director	10e. Street and Number	IORE	-	DICICI I	10f. Zic	Code				10g. C	itizen of W	/hat Coun	try?	_
	with so a		16 ROBIN LYNNE (	OURT					21128				ITED			
	eath	Funeral	11. Marital Status	12. Was Decede	ent Ever in III	S 121	Mac Doop				ifu Van as N			- Americ		
	iten Iten	ä	1 Never Married 2 Married	Amed Force	es?	0.   13.	f Yes, spe	city Cuba	n, Mexicar	n, Puerto R	cify Yes or N lican, etc.)		Blac	k, White,	etc.	
36	rs af	by F	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Date	_		1 🗆 Yes	2 🛚 No	Specify:				Specify	:WHIT	E	
8	4 within 72 hours after death with the Maryland liene. r than "natural", or tleme 23a or 28e-1 ehow the Madical Examiner must be positied at	ba	15. Decedent's Ed	L	, s.	16a. Deced	dont's Herr	al Ossuor	ation			165	Kind of Bu	ninons/Inc	hunta	
5	n 72	Completed	(Specify only highest gra	ide completed)		(Give	kind of wo	rk done o	turina mos	t of workin	g	100.	Killig of Bu	3111033/1110	lustry	
12	within lene. then	Ĕ	Elementary/Secondary (0-12)	College (1-4	or 5+)		EMBLY						B(	ок		
7	filed Hygie ther ant,		17. Father's Name (First, Middle, Last)			ADDI	TIDLI	DIII		ar's Nama	(First, Middl	Maide				
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Maryland 21215-0036	d 2 should th and Mer 7 le marke traumatic		19a. Informant's Name/Relationship ( PAT ROUFF/DAUGHT				-				Route Num.				45440	
	s 1 and f Healtl item 27 other t			. DIC	COL D		400-00-									
0	Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from Str		lace of Dispo emetery, crer	natory or c	me of other place			ate	20c. l	Location -	City or To	wn, State	
Ē	Pag ant: ury		4 Donation 5 Other (Specif		ST.	STANI				2/18/				-	ARYLAND	
Baltimore,	permit. Pa Departmen Important: eny injury once.		21. Signature of Funeral Service Licer	- / Cose	~/										ON INC.	
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77			23a. Part1. Enter the disease, or com shock, see neart failure. List only	plications that cou	sed the teath	. Do not ent	er the mod	e of dying	g, such as	cardiac or	respiratory	arrest,			Approximate Interval Between	
	Fnysician		Immediate Cause (Final		ERDS	CITE	807	-	CAL	Dul	NACL	. 1 1	2 .			
	/Medical		disease or condition resulting in death)		as a consequ		011	-	C7. /~		nsu	163	KD1	SEAS,	E	
9	Examiner				BETE	_										
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./	nsit	듣	Cause (Disease or injury	HYP	FRT	FNC	100	/						-		
V.	certificate be executed ding physician and se as the burial-transit	Examin	that initiated events resulting in death) Last	c. HyP Due to (or	as a consequ	ence of):	,0,									
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ita	ician: Th certificate rector, pag	a	25. Was case referred to medical						26. Place	of Death	(Check only					
>	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes ☐ No	Hospital:	atient 2 🗆 E	ER/Outpatien	t 3□ DC	Othe			e 5 Res		6 ∏Othe	or (Specify	•)	
0	g Ph er th		27. Manner of Death	28a. Date of I	njury	28b. Time of		8c. Injury Work			8d. Describe				/	
o	Attending it death.	tho	1 Matural 5 ☐ Pending 2 ☐ Accident investigation		Day Year)	Injury	м		?? ∕es 2 🔲	No						
Division of Vital Records,	dea ctor	flee	3 ☐ Suicide 6 ☐ Could not be	28e. Place of	Injury - At hor	me, farm, str	eet, factor	/. office		28	8f. Location	(Street a	ind Numbe	or Or Rura	Route Number,	_
á	afte Dire	Certification;	4  Homicide determined	building,	etc. (Specify	)					City or To	wn, Sta	te)			
	To the Hospital or Attending Physician: within 24 hours stier death of the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Pertifying Ph	ysicien: To the be	st of my know	vledge death	1 occurred	at the tim	e date an	nd plane ar	nd due to the	Caucol	s) and ma	nner ac et	ated	
	Ho 24 h Fur etely	edical	(Check only 2 Medical Examone)	niner: On the basis	s of examinati	ion and/or inv	estigation	, in my op	oinion, dea	th occurred	d at the time	, date ar	nd place, a	ind due to	the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier				290	c. License	number			29d. D	ate signed	(Month, I	Day, Year)	_
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	X		30. Name and address of person who	-	or death (Item	23a) (Type,	Print)	010		1000	dal/c	Λ.	10	71	221	
	U		21 Date filed (Month Day Yan-1	July 22 Day	istrar's Signat	WKe	1 1	140	2	unq	WU/C	14	1	212	-	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical 4c. County of Death **Examiner** 4b. City. Town, or Location of Death Baltimore ulane owson If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex Birthplace (State or Foreign Country) **Funeral** Months **Director** Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits or 28e-f show the Medical Examiner must be notified at Baltimore 1 Yes 2 □ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 332 tvenue 21215 230 "natural", or Iteme Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education ecify only highest grade completed) 16b. Kind of Business/Industry other than ary (0-12) College (1-4or 5+) d4 Fither's Name (First. Middle, Last) 18. Mother's Name (First Middle, Maiden Sumame Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve once. Rou Number, City or Tow State, Zip Code) atons ville 21228 20c. Location City or Town, State Surial 2 Cremation 3 Ren
Contact of Surial 2 Cremation 3 Ren
Contact of Surial Service Licensee 3 Removal from State Green ervices 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear value. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of and Il-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy signed by the atte in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No certificate has been si rector, page 2 should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No **Division of Vital** 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? completely filled in by the funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: Medicai Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury within 24 hours after death. To the Funerel Director; A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the I 29b. Signature and title of certifier 29c. Ligense number 29d. Date signed (Month, Day, Year) 1), 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J 31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

FEB 2 0

2008

Pathent Known as Betty Coe

				in Black Indelible Ink. yland / Department of F		uniona
			1 - State Registrar	Certificate of	Death	Reg. No. 2008 04994
	Physic /Medi		Decedent's Name (First, Middle, Last)  Be	etty Coe	2. Date of E Month	Day Year
3	Examin Funeral Director	ner	4a. Facility Name (If not institution, give street and number)  Single Hospital of Ba Himore  5. Social Security Number  6. Sex  1 M 2 F  Usual Residence of Decedent		r Location of Death  ORC CTY  If Under 24 Hrs. 8. Date of B. (Month, D. (Mont	4c. County of Death
	lanyland show ed at	'n	10a. State 10b. County 10	0c. City, Town or Location	D. Himana	10d. Inside City Limits 1 □ <b>X</b> es 2 □ No
	th the N or 28a-f e notifie	Director	Maryland N/A  10e. Street and Number	10f. Zip Code	Baltimore	10g. Citizen of What Country?
	sath wiss 23a		6641 Dalton Drive		21207	U.S.A.
215-0036	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. T is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Eve Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:	er in U.S. 13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	dispanic Origin? (Specify Yes or Nan, Mexican, Puerto Rican, etc.)  Specify:	14. Race - American Indian, Black, White, etc.  Specify: Black
	"natu	letec	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	pation during most of working	16b. Kind of Business/Industry
212	filed within Hygiene. Ither than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		les Person	Gold Lagoon
Maryland 2	2 should be filed and Mental Hygi is marked other aumatic event, tl	To Be C	17. Father's Name ( <i>First, Middle, Last</i> )  James Hicks		18. Mother's Name (First, Middl	le, Maiden Surname) Elouise Walker
lar)	2 sho and h is ma rauma	-	19a. Informant's Name/Relationship (Type, Print)			ober, City or Town, State, Zip Code)
	1 an Heal Sm 2		Theodore Hicks Son  20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place	Drive Baltimore, Marylai	nd 21207  20c. Location - City or Town, State
	permit. Pages Department of I Important: If ite any injury or o		1 Syrial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Funeric Stryice Lennee	Woodlawn Cemetery 22. Name and Address	& Chapel 02/16/0	8 Baltimore, Md.
60,	Physician Medical Medical Swaminer was as the prival-transit	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Due to (or as a condition of the cond	onsequence of):		Onset and Death 7 day 5
P.O. Box 68	5 # a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3 Ectopic pregnancy	1	23d. Date of delivery Month Day Year
ords, P	w requires that the d been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but no Africal Fibrillow 1001	ot resulting in the underlying cause give	THE STATE OF THE S	l tobacco use contribute to the cause of death? ]Yes 2∰No 3 □ Probably 4 □Unknown
al Reco	ate h	Completed			per 1□ Yes	opsy prior to completion of cause of death?  2 ☑ No 1 ☐ Yes 2 ☑ No
<u>.</u>	S S =	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient	2 ☐ ER/Outpatient 3 ☐ DOA Othe	26. Place of Death (Check only er: 4 □ Nursing Home 5 □ Res	one) sidence 6 □Other (Specify)
ivision	or Attending offer death. Director: After in by the fune	Certification: T	27. Manner of Death  1  Adural 5 Pending (Month, Day Ye)  2  Accident investigation	M 1 1	y at k? 28d. Describe k? Yes 2 □ No 28f. Location	(Street and Number or Rural Route Number, own, State)
:	within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only one)  1 ☑ CertifyIng Physician: To the best of m 2 ☐ Medical Examiner: On the basis of examiner and manner stated.	amination and/or investigation, in my o	pinion, death occurred at the time	e cause(s) and manner as stated. e, date and place, and due to the cause(s)
	To Son	Σ	29b. Signature and title of certifier	29c. License		29d. Date signed (Month, Day, Year)
,	11		30. Name and address of person who completed cause of death	(Item 23a) (Type, Print)	(-1 -6 0	February, 11, 2008 Itimore
	Sta Registr		31. Date filed (Month, Day, Year) 32. Pegistrar's FEB 2 0 2008	Sinai Hospit	al of Ga	It, MORE
	Registr	ar	FEB 2 0 2008	A Joil		

				Please	Type or Prir							gible.	
			For		State of Maryland / Department of Health and Mental Hyg							0.8	14995
			For State Registrar				Cert	ificate of	Death		Reg. No.	00	0 1 3 3 0
	Physici /Medic		Decedent's Name	e (First, Middle, La	si) Nina	(	2 art	e r		2. Date of De Month Februal	Day	ZOOS	3. Time of Death /2: 33 A-M
	Examin		4a. Facility Name (II	f not institution, giv	e street and number)	1	(	4b. City, Town, o	r Location of Deat	th	4c. Cou	nty of Death	
				zabeth	Nursin		enter	If Under 1 Year	If Under 24 Hrs	ore		None	alega (State or Foreign
	Funeral		5. Social Security N	1	Sex 7. Ag I□M 21X7F	3	last birthday)_ Yrs.	Months Days	Hours Min		ay, Year)	9. Birthi	place (State or Foreign http) th Carolina
	Director		238 30 9 Usual Residence of			91				Jali Z,	191/	IVOI	ui carorine
	yland		10a. State	10b. County		10c. Cit	y, Town or Loc	ation					10d. Inside City Limits
1	e Maria-f	cto	MD	Howard		El	licott	City					1 ☐ Yes 2. No
A	ih th	Dire	10e. Street and Nur					10f. Zip Code	,		10g. Citizen		
. <	death with the Maryland ms 23a or 28a-f show rmust be collified at	Funeral Director		Leisure	12. Was Decedent	Ever in 11	C 13 W	21043		Specify Yes or N		ed Sta lace - Ameri	
1	ter de	-un	11. Marital Status  1 □ Never Marri	ied 2 Married	Armed Forces?		1		tispanic Origin? (S an, Mexican, Puer	to Rican, etc.)	В	lack, White,	etc.
\ 0036	al', o	þ	3 ☐ <b>∜</b> Vidowed		If Yes, Give Year or Dates:		1	☐ Yes 2 █ <b>\</b> No	Specify:		Spe	<sup>cify:</sup> Wh	ite
5-0-5	72 hc	Completed	(Spec	15. Decedent's Edify only highest gra			(Give k	nt's Usual Occup ind of work done	during most of wo	orking	16b. Kind of	Business/In	dustry
121	within ane. than '	mpi	Elementary/Seco	ondary (0-12)	College (1-4or 5	5+)		O NOT use retired L'ESS	a)		Regi	tauran	+
d 21	filed Hygie ther		17. Father's Name	(First, Middle, Last,	)		Walt	TCDD	18. Mother's Na	me (First, Middle			
lan	ld be lental kad c	To Be	William	Shores					Gertrude	9	unknov	wn	
$\bigcup_{Maryland}$	shou and M s mar	-	19a. Informant's Na	ame/Relationship (	Type, Print)		19b. Mailing	Address (Street	and Number or R	ural Route Numb	er, City or Tox	vn, State, Zip	Code)
	and 2 salth in 27 I				one/Daught				ire Court				
Baltimore,	ges 1 of He If iten		20a. Method of Disp 1 X Burial 2		Removal from State	C	•	atory or other place		Date	20c. Locatio		
tii	t. Pag tment tant: Jury		* 4 ☐ Donation	5 ☐ Other (Specif	(y)	-		alley Ce		2–2008	Timon		
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show important; or other traumatic event, the Medical Examinar must be notified at ODGs.		21. Signature of Fu	. (30)	o- Withe	M010	77	Name and Addre	110				ily FH Inc. MD 21043
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death										
	Physician		Immediate Cause ( disease or condition	(Final	_ a.		eme	ntia					Veavs
	/Medical Examiner		resulting in death)		Due to (or as	a conseq		0 10.10					months
		-	Sequentially list con	onditions,	b Due to (or as	a conseq		exia					TV(OTT   VI)
	uted	Examiner	if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	erlying injury		(0	rona	rv ai	rterv	dise	ase		Vears
V	be executed sicien and burial-transit		resulting in death) I	Last	Due to (or as	a conseq	uence of):						
9760	ate be hysicie ihe bu	lical		(	d								
Box 687	ertific ding pl	Physician/Medic	IF FEMALE:		23c. If yes, outcome	of pregna	ancy				024	Date of deliv	an/
Bo	eath c attend for us	cian	23b. Was decedent in the past 12	months?	1 ☐ Live birth	2 Feta	Ideath 3 🗆	Ectopic pregnancy Other (specify)	у			Month	Day Year
P.O.	the d	ysi	1 ☐ Yes 2 ☐ 9 ☐ Unknown	No	9□ Unknown								
	The law requires that the death certificate ate has been signed by the attending physbage 2 should be detached for use as the	by P	Part II. Other signif	ficant conditions	contributing to death b	ut not res	ulting in the un	derlying cause giv	ven in Part I.				he cause of death?
rg	equire en sig		17/14	rtensi	m					1 🗆	Yes 2□No	3 Prol	bably 4 Minknown
900	elawr hasbe je 2 sh	Completed	Hypo	Hyrol	dism					24a. Wa auto	ppsy	prior to co	opsy findings available empletion of cause of
= =	The cate h	Con	Hype	erlipid	lemia					1 ☐ Yes	ormed? 2 <b>X)</b> No	death?	2X No
Vita	Physician: The this certificate ral director, pag	Be	examiner?	rred to medical	Hospital:			O#	nn 10	ath (Check only			
of	Phys r this ral dir	: To	1 Yes 2 2 27. Manner of Deat	<u> </u>	1 ☐ Inpatie 28a. Date of Inju (Month, Da		ER/Outpatient 28b. Time of	3 DOA	4 Nursing	Home 5 Res	how injury oc		fy)
on	rding F th. : After s funer	tion	1 ANatural 2 Accident	5 Pending investigatio		y Year)	Injury		rk?  Yes 2 □ No				
Divislon of Vital Records,	r Atter er dea rector by the	Certification:	3 Suicide	6 Could not b determined	28e. Place of Inj	ury - At ho	ome, farm, stre	et, factory, office			(Street and Nu	ımber or Rur	al Route Number,
0	oltal o urs eft ral Di	Cer		<b>V</b>									
	To the Hospital or Attending Physician: The law requir within 24 hours effer death.  To the Funaral Director: After this certificate has been si completely filled in by the funeral director, page 2 should	edical	29a. Certifier (Check only one)		hysicien: To the best miner: On the basis o and manner st	f examina							
	To the To the Comp	Me	29b. Signature and	title of certifier	2			29c. Licens	se number	01	29d. Date sig	ned (Month,	Day, Year)
			•		7	JM	20		1555	71	1-emu	ary	19, 2008
	7		30. Name and addr	ress of person who	completed perse of a	leath (Iten	/ 1	rint) ENUE,	Balt	imare	Ma	velan	nd 2122
	Sta	ite	31. Date filed (Mon	th, Day, Year)	32. Registr	ar's Signa	- 4	·	00111	71.77		7	/
	Regist		FEB'	2 0 2008	Missis .	AF A	The state of the s						

		For State Registrar	State o	f Marylan		artmen				,	giene	2008	nlac	16
Physicia	an	1. Decedent's Name (First, Middle					2. Date of Death Month Day Year  3. Time of Death				h			
/Medic	cal	ADA MAE	CATHCART			45 0:5:	F	1	- / B 11	Februa	ary 1	7, 2008		M
Examin	ner =	4a. Facility Name (If not institution Arcola Health	_					Spri				County of Dea		
Funeral	-	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bir	th	Montgor 9. Bir	thplace (State or For	eign
Director		427-44-2571	1 ☐ M 2 ☐ F	102	Yrs.	Months	Days	Hours	Min.	April 2	7, rear)	905 м	uintry). Ississippi	
and w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	v. Town or Lo	cation							10d. Inside City Lin	nits
Maryl f sho ied at	ŗ		gomery	Si	llver S	inrino	r						1 □ Yes 2 □	
r 28a	Director	10e. Street and Number	JOINEL Y	51	LIVCI	10f. Zip			_		10g. Citiz	en of What Co		
th witi 23a o ast be		2011 Sullivan 1	Lane			2	20906	5			U.S	S.A.		
tems tems	Funeral	11. Marital Status	Armed Fo	edent Ever in U. prces?	.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)					- 1	4. Race - Ame Black, Whit		
rs afte	by F	1 ☐ Never Married 2 ☐ Marr 3 🛛 <b>X</b> idowed 4 ☐ Divorced		1 □ Yes 2 ဩNo Specify:						Specify: Wh	nite			
2 hou latura ical E	ted	15. Decedent's Education 16a. Decedent's Usual O									16b. Kin	6b. Kind of Business/Industry		
thin 7 le. an "n Medi	Completed	Elementary/Secondary (0-12)	st grade completed) College (	1-4or 5+)	`life. l	kind of work done during most of working O NOT use retired)								
led wi lygier her th		Grade 8	1 - 1		Home	emaker	· 	40.14.11			l	vn Home		
d be final Hed other	Be	17. Father's Name (First, Middle, Joe Blake					's Name (First, Middle, Maiden Surname) :e Sloan							
shouk nd Me mark matic	은	19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailir	ng Address	(Street a			al Route Numb	er. Citv or	Town. State.	Zip Code)	
and 2 alth a alth a 27 is 27 is strat		Geneva Culver	/ daught	er	2011					lver Sp	-			6
es 1 a of He of He fitem		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	2 Damous from		Place of Dispo cemetery, crer	sition (Nam	ne of ther place	e)	1	Date	20c. Loc	ation - City or	Town, State	
Pag ment ant: It		4 Donation Mother (S	Specify) Entomb	ment Pa	ırklawn	Mem	Park	2	2/20	/2008	Rock	ville,	Maryland	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Integration of Health and Mental Hyglene. Integration if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funoral Service			22   D	2. Name an Onald	d Addres SON	s of Facili Fune	ral	Home, P	.A.			
40 = 60	Oi I	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate												
Physician		Immediate Cause (Final disease or condition resulting in death)  a.   Pneumonia  Due to (or as a consequence of):									11031,	1	Interval Between Onset and Death	
/Medical												2 weeks		
Examiner	_													
ed sit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury												
xecut al-tran	xan	that initiated events c												
filicate be executed physician and is the burial-transit	dical E	<b>L</b> <sub>d</sub>												
rtificat ng phy as th	a l		1000											
leath certific attending p	an/h	IF FEMALE: 23b. Was decedent pregnant   in the past 12 months?   23c. If yes, outcome pf pregnancy   1									23	23d. Date of delivery  Month Day Yea		
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M							Other (specify)			Month Day 1		Day real	
res that the signed by be detact		Part II. Other significant conditions contributing to death but not resulting in the underly						ause given in Part I. 23e. D				Did tobacco use contribute to the cause of death?		
w requires been sign should be	d by	Severe Dementia									1 ☐ Yes XX No 3 ☐ Probabiy 4 ☐ Unknown			wπ
aw re-	plete									24a. Was		24b. Were at	utopsy findings availa	ıble
The law cate has page 2 s	Completed									autoj perfo 1⊡ Yes	psy ormed? 2 <b>XOX</b> No	prior to death? 1 ☐ Yes	completion of cause	DT .
ician: Th certificate rector, pag	Be (	25. Was case referred to medica examiner?					T		e of Deat	h (Check only o				
Physi this c	2	1 ☐ Yes 2 ☐ X Y Y 27. Manner of Death	Hospital: 1 Inpatient 2 ER/Outpatie					ome 5 Residence 6 Other (Specify)			cify)			
ding h. h. After funer	tion	1 XNatural 5 Pending (Month, Day Year) 2 Accident investigation					f 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No			28d. Describe how injury occurred				
Attend r death ector; / by the f	ifica	3 Suicide 6 Could determ	not be 28e. Place	t be 28e. Place of injury - At home, farm, street, factory, office			office	28f. Location (Street and Number or Rural Route			ural Route Number,			
tal or rs afte al Dir	Certification:	building, etc. (Specify)						City or Town, State)						
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director; After this certifica completely filled in by the funeral director, p	Medical	29a. Certifier (Check only one) *** ** ** Certifyir 2   Medical	ng Physician: To the Examiner: On the b	asis of examina	wledge, death ition and/or in	n occurred a vestigation,	at the tim in my op	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) a date and p	and manner as place, and due	s stated. e to the cause(s)	
o the	Mec	29b. Signature and title of confie	- 1	ner stated.		290	License	number			29d. Date	signed (Mont	h, Day, Year)	
->		1 /30	Kow.	Kases	s Mi	1.	D098	34			Febr	uary l	8, 2008	
m		30. Name and address of person												
)		Barry Rosenbaum		720 Far gistrar's Signa		Avenu	e K	ensi	ngto	n, Mary	land	20895		
Sta Registr		31. Date filed (Month, Day, Year) FEB 2	0 2008	Comment of the control of the contro	K A	ments.	•							

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

1 - For State Registrar

		- 1	1. Decedent's Name (First, Middle, L	ast)				2. Date of Death	_	3. Time of Death		
	Physic /Medi		Marie Catherine	Corbin	_			February	14, 20	%8 8:00A		
Examiner			4a. Facility Name (If not institution, g			r Location of Death		f Death				
			Stella Maris Hos				nium		1	timore		
Į	Funeral Director			4 D M & T C	s. last birthday) 0 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Apr. 8,	1917	9. Birthplace (State or Foreig Country) Maryland		
21215-0036	land ow		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limit		
	leath with the Marylar ns 23a or 28a-f show must be notifled at	Director	Maryland Har	Air								
	a or the r		10 Glen Gate C	ourt	ourt			10	g. Citizen of What Country?  USA			
	death ms 2;	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13. V	21014  13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto F			14. Race -	I. Race - American Indian,		
	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show edical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 [XWidowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, Specify:	White, etc. White		
5-0	72 ho 'natuı dical	Completed	15. Decedent's I (Specify only highest g	Education rade completed)	16a. Deced	ent's Usual Occup	ation during most of worl	kina 1	6b. Kind of Busi	ness/Industry		
121	vithin one. han '	ם	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. [		during most of worl	9	O II	lam a		
	filed v Hygie ther t nt, th	8	17. Father's Name ( <i>First, Middle, Las</i>	(t)		Homemak		e (First Middle M	Own H			
Maryland	d be i	To Be			18. Mother's Name (First, Middle, Maiden Surname) Otila Barbara Chalone							
	should Me Me Mark		Lawrence Edmund  19a. Informant's Name/Relationship		19b. Mailin	a Address (Street		ral Route Number,		tate Zin Code)		
	s 1 and 2 should be filed within 72 ho of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical		Barbara Ensor /	Daughter	1			rrettsvil				
J.	es 1 a of He of He r othe	Ĭ	20a. Method of Disposition	20b.	Place of Dispos		1			ity or Town, State		
Ē	Pag lent nt: I		1 ☐ Burial 2 ☑ Cremation 3   4 ☐ Donation 5 ☐ Other (Spec			-	orp 2-1	5-08	Towson.	Maryland		
Baltimore,	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Lice		7 22	Name and Addres			TOMBOIL	That y Laria		
8	205 20		/ (use slig		- 113	117 Cokes	bury Rd.	Abingdo	n, MD 2	1009		
			23a. Part1. Enter the disease, or con shock, or heart failure. List onl	mplications that caused the dea y one cause on each line.	ath. Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death		
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. <b>DEMENTIA</b>						Onset and Death		
	/Medical Examiner		a a salary	Due to (or as a conse	quence of):							
		Examiner	Sequentially list conditions,	b. — Due to (or as a conse	quence of):							
	nsit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause Uniquity	200 10 (0) 40 4 001100	quoneo o.,.							
· Ć	executed n and ial-transit	Exal	that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):							
68760,	te be ysicia e bur	ca		d								
68	rtifica ng ph as th	Medi	IS SERVICE									
Вох	eath certificate be executed attending physician and for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregr 1 ☐ Live birth 2 ☐ Fet	nancy tal death 3□	Ectopic pregnancy	,		23d. Date of delivery Month Day Year			
	e des the at red fo		in the past 12 months? 1 □ Yes 2 🕱 No 9 □ Unknown	4□Pregnant at time of 9□Unknown		Other (specify)						
P.0	The law requires that the de ate has been signed by the a bage 2 should be detached 1		Part II. Other significant conditions	contributing to death but not re	culting in the un	darlying cause give	on in Part I	23a Did toba	ann usa contrib	oute to the cause of death?		
ds,	ires t signe	b	Taren. Other organization conditions	denying cause givi	en in raiti.	1	es 2 No 3 Probably 4 ∏Unknow					
Ö	w require been sign	Completed										
Rec	ne lav has ge 2 :	E E						24a. Was an autopsy perform	l pri	ere autopsy findings availabl or to completion of cause of ath?		
ā	in: Ti ificate or, pa		25. Was case referred to medical	T			00.00	1  Yes 2	No 1L	]Yes 2□No		
>	Physiclan: r this certifica ral director, I	o Be	examiner?  1 \( \sum \text{Yes} \) 2\( \sum \text{No} \)	Hospital: 1   Inpatient 2	ER/Outpatient	3 □ DOA Othe		h (Check only one,		MOGDICAL		
Division or Vital Records,	g Phy er this eral c	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injur Worl		28d. Describe how		(Specify) HOSPICE		
Ö	Attending ir death. ector: After by the fune	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury		Yes 2 □ No					
Vis.	after death.  Director: /	EH CC	3 Suicide 6 Could not le 4 Homicide determined	28e. Place of injury - At h building, etc. (Spec	street, factory, office  28f. Location (Street and Number or Rural Ro City or Town, State)				or Rural Route Number,			
Ö	Ital or rs after ral Dir	Certification:		la contraction of the contractio					ŕ			
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	Medical	29a. Certifier (Check only one)  1 Certifying P 2 Medical Example	hysician: To the best of my kn miner: On the basis of examin	owledge, death ation and/or inv	occurred at the tin estigation, in my o	me, date and place, ppinion, death occur	and due to the car red at the time, da	use(s) and manr te and place, an	ner as stated.  Id due to the cause(s)		
	o the ithin 2 the o the o the o the omple	Med	29b. Signature and title of certifier	and manner stated.		29c, License				29d. Date signed (Month, Day, Year)		
B	F 3 F 8			/n			3725	1	2/14			
	^	-	30. Name and address of person who	completed cause of death (Ita	m 23a\ (Tvne F		3165					
	10		DR. TARIO MAHMOO				TMONTIM	MD 21093				
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign			TIOHITOHI	TM 71023				
	Registr	ar	FEB 2.0 2008	paran A	A STATE OF	•						
DH	MH 17 Rev 1/2	001										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 5:15p <sup>™</sup> FEBRUARY 2008 WINSON R. COLEMAN JR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** BALTIMORE GWYNN OAKS 11 TORLINA CT. APT A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2 ☐ F NORTH CAROLINA 5-26-1939 Director 68 244-58-9163 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show e notifled at 1 XYes 2 No Funeral Director GWYNN OAKS BALTIMORE MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or Items 23a or dical Examiner must be r 21204 USA 11 TORLINA CT. APT A 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Yes 27 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ★ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2√∑ No Specify:BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) UNIVERSITY OF Elementary/Secondary (0-12) College (1-4or 5+) DISTRICT OF DIRECTOR OF SCIENCE AND ENGINEERING -12--8-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be THEODORA DUGAS WINSON R. COLEMAN SR. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6317 GEORGETOWN BLVD. ELDERSBURG, MARYLAND 21784 CELESTINE R. COLEMAN(WIFE) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2xx Cremation ō 3 Removal from State Department of Important: If any injury or once. 2-18-2008 METRO CREMATORY BALTIMORE, MARYLAND 5 ☐ Other (Specify) 4 □ Donation 21. Signature of Funeral Service Licensee JONATHAN D. HIBNER. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediat Cause (Final disease or condition resulting in death) Se **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, IF FEMALE If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has be rector, page 2 s performed 2 No 26. Place of Death (Check only one) 25. Was case referred to medica Medical Certification: To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 | Yes 2 | No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural ours after death.

Ieral Director: A
filled in by the fu 2 ☐ Accident Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

G Division or Vital Records,

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certi

31. Date filed (Month, Day, Year)

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 32. Registrar's Signature

Newland Ed

within 24 hours a

🛮 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Feb 14, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 8 pstaternf, Massa, not Deposing to Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** ofie 7=46 AM Tatti 1, 02 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA University of Maryland Medical Center Baltimore if Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 1 □ M 2 🖾 F <sup>(Month</sup> Pay **501/26/19**49 212-58-0230 Director MD Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Baltimore DXXYes 2 □ No Director MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21201 USA 116 N. Paca Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. be filed within 72 hours after 1 ∐ Yes 21⁄27√No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 → No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9 clerk Eddie's Supermarket 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event any Injury or other traumatic event once. Be Ester Osborn Albert Monks ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Cofiell / Daughter 1921 W. Harlem Avenue; Baltimore, Maryland 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X urial 2 ☐ Cremation 3 ☐Removal from State Mount Zion Cemetery 02/23/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) M40 cardial infarction **Physician** 8 hours /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 **M**Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cardiogenic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performe The 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA After this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca 29a. Certifier

O. ۵. Records, Division or Vital Hospital or Attending Physician: within 2 To the

> State Registrar

31. Date filed (Month, Day, Year) FEB 2 0 2008

(Check only one)

29b. Signature and title of certifier

Sara M. Handy

University 32. Pojistrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

of Maryland Medical Center, 22 S Greene St. Bulhmire, MD 21201

29c. License number

17418

29d. Date signed (Month, Day, Year) Feb, 14, 2008